

Developing a Comprehensive Sexual and Reproductive Health Policy Framework: A Case-Study Review



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Foreword

This year, the global community marks the 20th anniversary of the International Conference on Population and Development (ICPD), held in Cairo where the world leaders from 179 countries forged a groundbreaking consensus that changed the very terms of development. Cairo marked a turning point on the path towards equitable and inclusive sustainable development, shifting population policy and programmes from a focus on numbers to a focus on individual human lives and rights. Delegates from all regions and cultures agreed that the access to sexual and reproductive health is a key strategy for achieving the overall development goals. They recognized that empowering women and girls is one of the most effective ways to improved well-being for all.

Good sexual and reproductive health (SRH) is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are entitled to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so. When sexual and reproductive health needs are not met, individuals are deprived of the right to make critical choices about their own bodies and futures, with a cascading impact on their families' welfare and future generations.

Since the ICPD, many countries in various regions have developed a comprehensive SRH policy frameworks tailored to their national context in order to guide advocacy, planning, investment, implementation and monitoring of national efforts in promoting sexual and reproductive health (SRH). These policy frameworks facilitate a comprehensive and holistic approach to addressing many inter-related aspects of SRH.

In the last two decades, China has made marked progress in reproductive health, especially in preventing and reducing maternal morbidity and mortality. It has instituted targeted policies for selected SRH issues, such as maternal health, family planning, STIs and HIV, and reproductive cancers. However, it is lacking an overarching SRH policy framework, which can serve as a basis in identifying gaps and formulating polices for other priority issues, such as unmet needs of young people for SRH, health sector response to victims of gender-based violence, among others. These issues are

inter-related and significant impact can be achieved if addressed comprehensively. With the success on many aspects of the SRH, China is now in a position to expand its policies and programmes to address a wider range of sexual and reproductive health issues.

Commemorating the ICPD Beyond 2014 at the Sixth Asian and Pacific Population Conference in September 2013, the Government of China, and other members and associate members of the United Nations Economic and Social Commission for the Asia and the Pacific, have adopted the Asian and Pacific Ministerial Declaration on Population and Development. The Asian and Pacific Ministers committed to accord priority to policies and programmes to achieve universal access to comprehensive and integrated quality sexual and reproductive health services.

As a follow up to this commitment, UNFPA and the national partners in China plan to develop a proposal for a national comprehensive SRH policy framework. In preparation for this, UNFPA supported a case study review of the existing SRH policy frameworks of other countries in different regions, highlighting good examples as well as key factors defining core content and scope of such policy framework. The report presents the cases of thirteen countries across a range of different levels of social and economic development. We hope that together with other references, the report will be a good resource for ensuing policy discussions and dialogue.

UNFPA in China would like to express sincere gratitude to Dr. Sarah Hawkes for her guidance and contribution in finalizing the report and to Ms. Maeva Peek for her dedicated work in preparing this review based on extensive research.



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SUMMARY

INTRODUCTION

Good sexual and reproductive health (SRH) is fundamental to ensuring that individuals, families and populations live lives that are healthy, sustainable and meaningful. Poor sexual and reproductive health is associated with a huge burden of disease at national and global levels: 500 million new (curable, non-viral) sexually transmitted infections every year; a quarter of a million women dying in childbirth; over 200 million people with an unmet need for family planning; and a majority of adolescents and young people in the world still have incorrect and inadequate knowledge around fundamental issues such as HIV. In China, poor sexual and reproductive health results in an estimated 48,000 new infections and 28,000 deaths from HIV per year, about four thousand women dying in childbirth, one quarter of women experience violence at some point in their lives, and 14% of men in one Chinese study reported perpetrating rape against a female partner.

At the heart of SRH lies the concept of healthy sexuality – meaning a safe and satisfying sexual life, a positive attitude to sexual relationships, and freedom to express sexual and gender identity. Healthy sexuality, in turn, relies upon the protection, promotion and enabling of fundamental human rights in relation to sexuality.

Evidence highlights that SRH outcomes are driven by a number of factors at three linked levels - macro (policy and structural levels), meso level (family, community and social norms) and micro level (individual characteristics and behaviours). Improving SRH means both understanding these drivers and ensuring policies and programmes act

upon multiple levels. Importantly, many of these drivers are outside the sphere of influence of the health and population sectors - thus emphasizing the need for intersectoral coordination and collaboration to enable SRH goals to be reached. Furthermore, cross-cutting issues such as gender act across all three levels, and should be taken into consideration in policy and programme responses.

Most countries in the world have made commitments to improve and ensure good sexual and reproductive health for their populations. A number of international conferences (such as the International Conference on Population and Development, and the World Conference on Women) have outlined the issues to be addressed, and global goals (such as the Millennium Development Goals) have seen countries commit to achieving improvements across a number of SRH outcomes. Moreover, new mechanisms for accountability – such as the Independent Expert Review Group (iERG) which reports regularly to the UN Secretary-General on the results and resources related to the Global Strategy for Women’s and Children’s Health, and the United Nations General Assembly Special Session on HIV/AIDS (2001) – have ensured that national governments are now held accountable on the commitments they make. Importantly, these accountability mechanisms involve both national governments and civil society, including representatives of affected communities. These accountability mechanisms have promoted increased participation and greater transparency for SRH commitments.

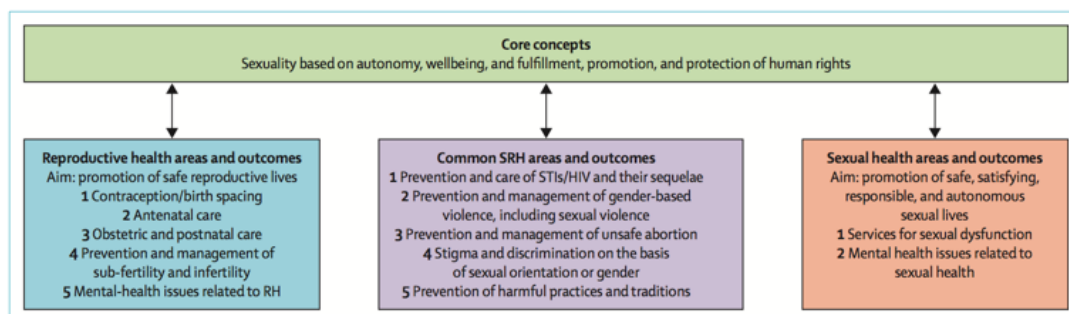


Figure: Core concepts underlying sexual and reproductive health
STIs=sexually transmitted infections. RH=reproductive health. SRH=sexual and reproductive health.

Improving outcomes in sexual and reproductive health means delivering integrated, holistic policies and programmes that address a number of different domains – see Figure which illustrates not only core concepts, but also programmatic areas to be addressed:

THIS REPORT

Within this report we have reviewed the global evidence and rationale for the key concepts and components of comprehensive policy and programme frameworks for sexual and reproductive health and rights (SRHR). Having established the underlying principles and identified the key thematic areas, we then review SRHR policy frameworks across thirteen countries– each one selected either for their exemplary status as leaders in SRHR policy and promotion, for their comprehensive and well-integrated approach to delivering SRH services within the wider public health policy framework, or for their marked recent developments and improvements in the area of comprehensive SRH policy.

Combining the underlying concepts of SRHR along with in-depth country case studies, we identify a number of key issues for consideration for China. These key findings will be of interest for all people concerned with developing, formulating and implementing

policies and programmes to improve SRHR in China.

KEY FINDINGS FROM REVIEW UNDERLYING CONCEPTS AND NATIONAL LEVEL CASE STUDIES

1. **SRHR is fundamental to promoting and protecting the health of populations**, to advancing human wellbeing, and to ensuring services respond to the needs of individuals. While SRHR commitments have been made by a large number of countries, fewer countries have gone on to develop comprehensive SRHR policies and programmes.
2. A **supportive legal and policy framework is crucial** to enable individuals to achieve their SRHR goals. International commitments to promote and protect SRHR have been used to guide the content of national Government policies, as well as providing mechanisms to hold Governments to account by individuals, communities and in particular by affected communities. China already has a large number of national laws in place which can be used to promote and protect SRHR goals.
3. **Accountability is vital**. Mechanisms for accountability have been used in other ongoing frameworks within SRHR – in particular, the HIV-UNGASS and Independent Expert Review Group for women and children’s

health. These mechanisms not only enhance the core concept of accountability, but also improve transparency and may act to increase the efficiency of systems.

4. SRHR should be realized by everyone in a population, but **the exact needs of individuals vary** according to socio-demographic and other factors (age, location, gender, sexual orientation, etc). Programmes at national level have recognized that different groups in society have different needs, and services have been directed to respond to the needs of these different groups.

5. **Health care financing mechanisms for SRHR vary** between countries – ranging from general taxation, and hypothecated taxation, through to donor financing. Deciding on individual Government responsibilities for financing of a core package of SRHR services is vital.

6. Moving from single-issue reproductive health programmes (e.g. family planning programmes) towards comprehensive SRHR policies and programmes has tended to **proceed in a step-wise fashion** in many countries. Many of the countries reviewed are still in the early stages of SRHR service delivery and are focusing on a restricted package – e.g. concentrating on improving reproductive health programmes. Other countries, with longer histories of SRHR services, are able to deliver more comprehensive models of care that are accessible to the whole population, as well covering a larger number of programmatic components.

7. Most policies reviewed focus on preventing disease rather than on promoting wellbeing or enabling rights. This may be missing some of the more important (but less tangible) aspects of SRHR such as wellbeing, mental health associated with sexuality, concepts of pleasure and satisfaction, etc. Furthermore, **programmes which take a more holistic**

approach and focus on all aspects of SRHR have been shown to be more acceptable to clients, and have improved impact in some cases.

8. **Monitoring and evaluation are crucial**. The more comprehensive programmes measure not only disease-based outcomes, but also take user perspectives into account.

9. **Improvements in SRHR begin with the health sector, but cannot be achieved by the health sector alone**. The role of legal, educational and other sectors is crucial. Cross-sectoral collaboration is vital.

In summary, the lessons learnt from other countries, particularly when reviewed in the light of underlying core concepts and principles of SRHR, will be useful in strengthening China's existing SRHR policies and expanding the scope, reach, and quality of SRHR programmes.



I. INTRODUCTION

Sexual and Reproductive Health and rights (SRHR) have been placed at the centre of programmes for sustainable social and economic development for at least the past two decades. In 1994, the International Conference on Population and Development (ICPD) identified access to reproductive and sexual health programmes as a key strategy for achieving overall development goals:

“population-related programmes play an important role in enabling, facilitating and accelerating progress in sustainable human development programmes, especially by contributing to the empowerment of women [and] improving the health of the people”.¹

Prior to the 1994 ICPD, international agreements such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979 enshrined an international commitment to ensure equality in access to health services (including family planning services – Article 12), elimination of “discrimination against women in all matters relating to marriage and family relations”, and articulated the rights of both women and men to decide on issues of human reproduction.

A year later, at the 1995 Fourth World Conference on Women (held in Beijing), the links between sexual and reproductive health, social determinants and overall social development, were further reinforced by the international community:

“The prevalence among women of poverty and economic dependence....the limited

power many women have over their sexual and reproductive lives and lack of influence in decision-making are social realities which have an adverse impact on their health.Good health is essential to leading a productive and fulfilling life, and the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.”²

Investments in SRH contribute to goals of empowerment, particularly women’s, through increasing abilities to make informed decisions related to partnerships, sexual behaviour and family planning free of coercion, discrimination, and violence; all of which allows for greater female participation in the workforce - itself a logical requisite for equitable and sustainable economic growth³.

Over at least the past two decades, countries have both embraced the concept of comprehensive SRHR, and simultaneously struggled to define what SRHR means to individuals, families, communities and populations, and how people can be supported to achieve their SRH goals.

In the broadest terms, SRH goals are currently enshrined within the Millennium Development Goals (MDGs) – MDG 5 focuses entirely on reproductive health while MDG 6 has some elements of sexual health in its indicators (HIV prevalence in young pregnant women, condom use at last “high risk” sex, and correct HIV “knowledge” among young people). Moreover, MDG 3 is focused on gender – with its close links to SRHR. These goals are likely to

1.Report of the Fourth World Conference on Women, Beijing, September 1995. Section 9.2. Accessed at: <http://www.un.org/womenwatch/daw/beijing/pdf/Beijingfullreport.pdf> Paragraph 13.11
2.Report of the Fourth World Conference on Women, Beijing, September 1995. Section 9.2.
3.UNFPA:2010 p. 19

be continued, in some format, within the post-2015 Sustainable Development Goals agenda.

This global focus on SRHR is partly based on a concern with the high contribution that risks arising from unsafe sexual practices make to the global burden of disease. Equally, there is a deep-seated global concern to ensure that everyone has the right to the highest attainable standard of health, and an acknowledgement that good sexual and reproductive health are fundamental to human well-being.

The report starts with a conceptual overview that defines SRHR as understood by many policies at both global and national levels, and reviews the fundamental principles that underlie improvements in SRHR. We then review the programmatic areas that countries often deliver as part of policy implementation. The second part of the report is devoted to exploring case studies of countries that have successfully promoted SRHR policies over the past two decades. Finally, we conclude with a review of what the underlying concepts and on-the-ground country experiences might mean in the context of China.

This report has three main goals:

- (1) To outline the evidence underlying key concepts and components of a comprehensive Sexual and Reproductive Health and Rights policy framework,
- (2) To review SRHR policy frameworks using a case study approach across a range of different regions and stages of socioeconomic development
- (3) To identify key lessons learnt for the future development of a comprehensive sexual

and reproductive health and rights policy framework for China

KEY CONCEPTS AND COMPONENTS

Sexual and reproductive health and rights (SRHR) lies at the core of ensuring that individuals, families and populations live lives that are healthy, sustainable and meaningful. The evidence base for the burden of disease associated with poor sexual and reproductive health is staggering: 500 million new (curable, non-viral) sexually transmitted infections every year; a quarter of a million women dying in childbirth; over 200 million people with an unmet need for family planning; and a majority of adolescents and young people in the world still have incorrect and inadequate knowledge around fundamental issues such as HIV. In China, poor sexual and reproductive health results in an estimated 48,000 new infections and 28,000 deaths from HIV per year⁴, about four thousand women dying in childbirth, one quarter of women experience violence at some point in their lives, and 14% of men in one Chinese study reported perpetrating rape against a female partner⁵.

The burden is substantial, but so is the evidence base both outlining the determinants of the problem as well as identifying effective interventions to reduce ill-health and promote well-being.

SRHR has been defined through international conferences, commitments and covenants for the past several decades – and **Appendix 1** includes summaries of the accepted definitions of these terms. At the core of SRHR lies healthy sexuality - defined in this document as achieving a safe and satisfying sexual life, attaining a positive attitude

4. Data from UNAIDS China website: <http://www.unaids.org.cn/en/index/page.asp?id=197&class=2&classname=China+Epidemic+%26+Response>

5. Research on Gender-Based Violence and Masculinities in China. Research funded by UNFPA in collaboration with Partners for Prevention, UNDP, UNWomen and UNV. Report available at: <http://www.unfpa.cn/en/publication/research-gender-based-violence-and-masculinities-china-quantitative-findings>

to sexual relationships, and freedom to express one’s sexual and gender identity. Recognition of the central role of sexuality is not a new concept⁶, but it is nonetheless frequently overlooked at the level of policy and programmatic responses. Re-focusing policy and programme efforts to acknowledge sexuality is key to achieving good sexual and reproductive health outcomes.

Sexual and reproductive health (SRH) are linked at every level – from the experience of the individual, through to the delivery of integrated and holistic packages of services and interventions aiming to improve SRH for individuals, communities and broader societal groups.

Despite these obvious overlaps between sexual and reproductive health, challenges for truly integrated and holistic policies and programmes remain. Not only are these health outcomes seen as the responsibility of different programmes (maternal health or services for relationship counseling, for example), they are also subject to separate rules and norms, funded through separate streams, and written about by different groups of academic and activist communities. Nonetheless, important areas of overlap do exist.

Figure 1 outlines the conceptual overlap between different programme and policy areas for sexual and reproductive health, and recognizes the central role that healthy sexuality plays across all these areas.

Figure 1: Core concepts underlying sexual and reproductive health and rights⁷

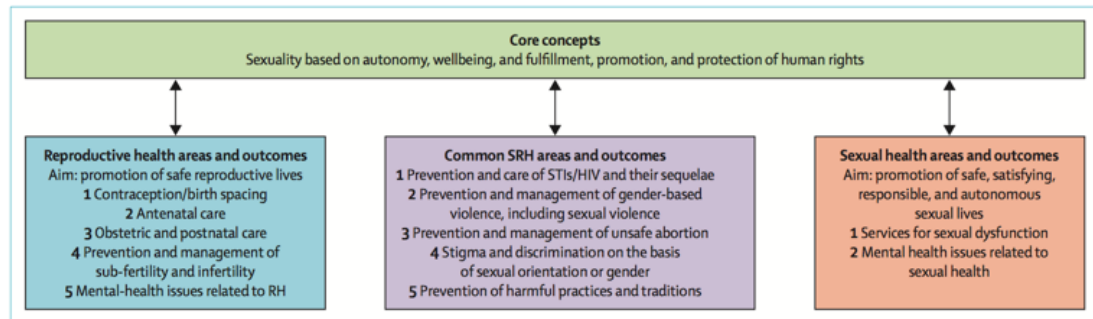


Figure: Core concepts underlying sexual and reproductive health
STIs=sexually transmitted infections. RH=reproductive health. SRH=sexual and reproductive health.

6. Dixon-Mueller R. The sexuality connection in reproductive health. *Studies in Family Planning*, 1993;24(5): 269-282
7. Hawkes, S. Sexual health: a palimpsest for post-2015. *Lancet Global Health*, 2014;2(7):377

WHAT DRIVES SRHR?

Vulnerability to poor sexual and reproductive health outcomes is driven by a complex interaction of factors at three linked levels – macro (policy and structural levels), meso level (family, community and social norms) and micro level (individual characteristics and behaviours). These drivers act either directly on SRH outcomes, or they act through their influence on the expression of sexuality which, in turn, influences SRH outcomes.

The importance of understanding these drivers lies in identifying the areas where interventions are needed to ensure that people can fulfill their sexual and reproductive health goals, and their risk of poor health is minimized. Importantly, many of the drivers are outside of the sphere of influence of health and population programmes– thus emphasizing the need for intersectoral coordination and collaboration to enable SRH goals to be reached.

While it is conceptually clear to think of drivers at three levels, it is important to recognize cross-cutting issues such as gender power imbalances which operate across all levels, and the fact that the drivers rarely operate independently of each other: young women from poor households may be less likely to go to school and hence have less knowledge or agency with which to protect themselves from unwanted pregnancies; men from poor families may be more likely to migrate alone

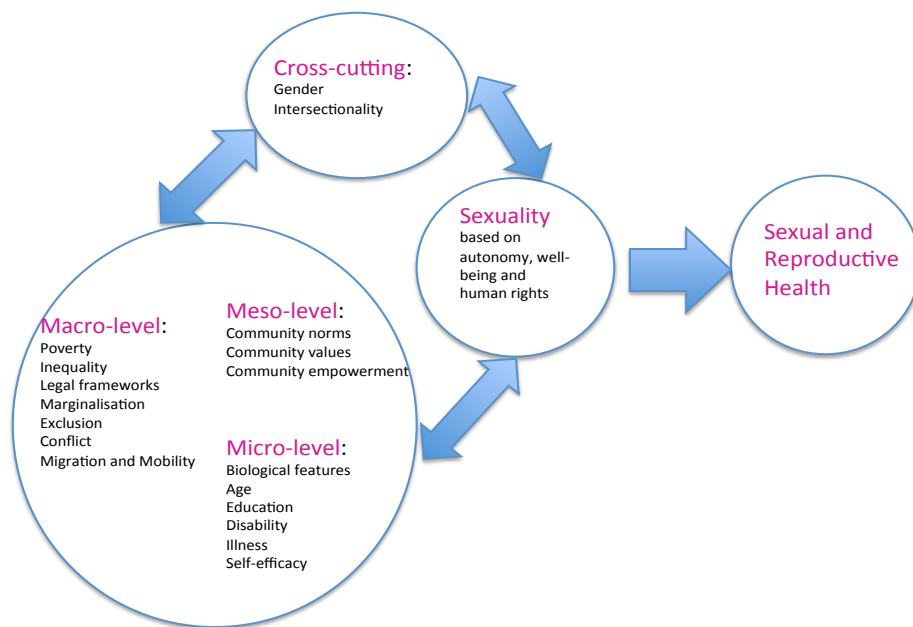
to urban settings and seek sexual satisfaction and pleasure within commercial sexual relationships. While it is often important to find evidence on the strength of association between each of these individual drivers (poverty, income inequality, education, migration status, urban residence, etc) and SRH outcomes, it is probably less useful than recognizing that the intersectionality of variables may act to increase and reinforce risk and vulnerability⁸ for many.

Gender, and in particular, gender equality, gender equity, and the empowerment of women, are core to achieving SRH goals. However, a focus on the sexual and reproductive health needs of girls and women, although crucial, is insufficient to promote universal SRHR. Recognising the specific SRHR needs of men and boys, and ensuring their involvement in programmes is vital to enabling everyone to achieve SRHR goals. An approach which mainstreams gender into all aspects of SRHR requires recognizing the importance of gender at all stages of policy cycles – from agenda setting through policy development and on to programme delivery, thus ensuring that gender equitable SRHR policies and programmes are developed and delivered. It also implies recognizing

With these caveats, Figure 2 outlines the three levels of drivers influencing SRH outcomes, and highlights that there are issues of cross-cutting and intersectionality to recognize and act upon.

8.Crenshaw KW. Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color, *Stanford Law Review*, 1991; 43(6):1241–1299

Figure 2: conceptual model of the drivers and outcomes of sexual health and reproductive health.



DELIVERING SRHR SERVICES

A number of key principles underlie the delivery of SRHR services.

- o Universal access
- o Life course approach
- o Quality of care
- o A rights-based approach

UNIVERSAL ACCESS:

Paragraph 7.6 of the ICPD Programme of Action calls for countries to make SRH services accessible through the primary healthcare system – thereby increasing access for all, irrespective of age, gender, socioeconomic strata, or any other characteristic. This

position, of promoting universal access, is supported by UNFPA⁹. In the past 20 years, however, it has become increasingly clear that health systems overall need to be strengthened in order to secure universal access to SRHR, usually through financing, legislation, and regulatory mechanisms¹⁰, - which are further discussed below.

On the demand-side of SRH programming engagement at the individual, household and community levels is required as a lack of trust and engagement with services can lead to their non-use. Strategies to promote engagement may include community mobilization, media engagement, school-based programmes, and partnerships with civil society organizations. Such measures not only

9.UNFPA SRH for ALL 2010 p. 15

10.ST Fried et al. Reproductive Health Matters 2013;21(42), 57

promote the use of services and maximum returns on public investment, but also improve individuals' choices and self-efficacy.¹¹

A LIFE-COURSE APPROACH TO SRH

UNFPA supports a tailored life-cycle approach to SRHR, recognizing the different reproductive and sexual needs of individuals at every stage of their lives¹². Such stages include infancy and childhood, adolescence, reproductive years, and post-reproductive years. This approach also makes it possible to address the causes of ill sexual and reproductive health early on in an individual's life, recognizing that problems in adulthood often have their roots in negative exposures during childhood and early adolescence.

QUALITY OF CARE

Quality of healthcare at the level of service-provision level has been defined as including six measurable domains: provision of choice; availability of information and counseling for clients; technical competence; good interpersonal relations; continuity of care; and an appropriate constellation of services (as well as follow-up and continuity methods and treatment protocols).¹³

Essential to performing well in these areas is a strengthened health system which includes human resource development including comprehensive training programmes for healthcare providers – with an emphasis not just on skills but also on the quality of the care provided. Training opportunities should be seen as part of a life-long approach to health worker development: training curricula in pre-qualification settings (medical school, nursing and midwifery schools etc), continuing

professional development programmes and measures to invest in and retain skilled health personnel,¹⁴

A RIGHTS-BASED APPROACH TO SRH SERVICES

There is a fundamental relationship between SRH, human rights and legal responses. Some of these legal relationships are direct – for example, laws protecting against discrimination on the grounds of gender or sexuality, laws protecting privacy, or laws guaranteeing equity in access to services. In addition, the law can be used to promote and protect the social environments and social determinants of everyone's health. Governments have obligations to meet the rights of all individuals to reach their SRH goals.

China has already put in place a number of laws that protect and promote rights in relation to SRHR – a list of laws is found in Appendix 2. These laws range from protecting children's rights by setting the legal age of marriage as 20 for women and 22 for men (thus ensuring that children cannot be married), to several laws protecting women and girls against gender-based violence. Same sex relationships are not criminalized in China, and there is some protection afforded to transgender populations – e.g. through access to services for gender reassignment. Nonetheless, there are other areas where laws protecting basic SRH rights are currently absent - for example, there is no legal recognition of marital rape, and persons "engaging in prostitution or visiting a whorehouse knowing that they are suffering from syphilis, clap or other serious venereal diseases" can be sentenced to prison for up to five years.

11. UNFPA 2010 p. 15

12. UNFPA, Reproductive Health: The Life Cycle Approach. Available at <http://www.unfpa.org/rh/lifecycle.htm>

13. WHO Quality of Care in the provision of sexual and reproductive health services 2011. p. 2

14. WHO Reproductive Health Strategy 2004 p. 22

A FOCUS ON POPULATIONS

Although everyone has a right to the highest possible level of sexual and reproductive health care, specific populations are highlighted as being particularly in need of SRH interventions: young people, people with physical disabilities and chronic illnesses, incarcerated populations, sex-working populations, marginalized populations, and minority (indigenous or ethnicity) populations.

Migrants¹⁵, people living in remote areas, people marginalised on account of their gender or sexual orientation, sex workers, refugees, ethnic minorities, and those below the absolute poverty line may sometimes have higher levels of risk-taking or lower levels of agency to reduce risk - thus resulting in poorer SRH outcomes. Policies and programmes for SRH services must act to ensure equity in access to services for all population groups.

For many parts of the world, SRH services tend to be focused on reaching women, particularly married women – who are generally the group with access to maternal and child health services, family planning services, antenatal services, etc. This can lead to an exclusion of services accessible by men – whose sexual health needs are often not met by public sector services. Moreover, men are often ignored in policy and programme development – indeed they have been described as the “forgotten 50%” in relation to SRH services¹⁶. When men are included in SRH programmes, it is often in relatively negative terms or as a conduit for improving women’s SRH outcomes. As a result of inequities in access, men have been found to suffer poorer SRH outcomes when compared to women in some places –

for example, in sub-Saharan Africa men have lower HIV testing rates compared to women, and disproportionately fewer men access anti-retroviral therapy, they access later in the course of their illness, and they are more likely to die even when taking therapy¹⁷. The evidence base on what works to engage men, on the role of gender norms influencing men’s uptake of services or interventions, and, fundamentally, men’s knowledge of SRH, is poor. Addressing these gaps in evidence may lead to better health outcomes for both men and women.

A FOCUS ON YOUNG PEOPLE

COMPREHENSIVE SEXUALITY EDUCATION

Young people, in particular, are the focus of many sexual health interventions, including through engagement in sexuality education – designed to both promote positive aspects of sexuality, as well as to protect against adverse sexual health outcomes both immediately and over the longer-term. The purpose of interventions aimed at young people is to provide support and guidance at a critical stage of their development – guidance which is based on both imparting factual information about sexual and reproductive health, building essential lifeskills, and providing a supportive environment for young people, including the active involvement of parents and other trusted adults and access to necessary health resources and services. Education, counseling and other interventions for young people should support the development of decision-making, communication, and goal-setting skills, respect for others, the promotion of core values associated with sexual health, and enable young people to develop a healthy

15. Adanu and Johnson 2009 P. 179

16. Varga, C. A. (2001) ‘The forgotten fifty percent: a review of SRH research and programs focused on boys and young men in Sub-Saharan Africa’, *African Journal of Reproductive Health*, 175-195.

17. Cornell, M., Grimsrud, A., Fairall, L. (2010) ‘Temporal changes in programme outcomes among adult patients initiating anti-retroviral therapy across South Africa 2002-2007’, *Aids* 24: 2263-2270

sense of sexual identity and responsibility.

Adolescents (defined as the 10-19 age group by the WHO) and young people (defined by UNFPA as spanning from 10-25) are particularly at risk of SRH ill-health - including unplanned or early pregnancy, early or forced marriage, HIV and STI transmission, mental health problems, violence (sexual or otherwise), and gender and sexual identity issues. In 2014, the global adolescent birthrate was estimated to be at 49 per 1000 girls - ranging from 1 to 229 births per 1000 girls¹⁸. Complications in teenage pregnancy were listed as the leading cause of death for girls in developing countries. Further, more than two million adolescents are currently living with HIV, and in 2010 it was estimated that of the nearly 20 million unsafe abortions performed yearly, the vast majority of which occur in developing countries, 14% of the women having them done are under the age of 20¹⁹.

Providing young people with better information, not just about contraceptives and family planning, but also about other aspects of sex and relationships (namely through a life-skills based approach to Comprehensive Sexuality Education), as well as ensuring universal access to confidential and youth-friendly services is crucial to addressing these problems²⁰. Parallel efforts should be made to expand service delivery to groups of young people that are harder to reach; including, young people who do not attend school, or who are unemployed, refugees, young migrants, LGBT youth, and young sex workers, among others.

Comprehensive sexuality education (CSE) is a core component of services for young people. It can help all children and young

people to achieve the skills needed to become responsible and sexually healthy members of society. UNESCO has identified the primary goal of CSE as “children and young people become equipped with the knowledge, skills and values to make responsible choices about their sexual and social relationships”. UNESCO further stresses the importance of CSE that is evidence-based, age-appropriate, gender-sensitive, and life skills-based. UNFPA has proposed the following core elements of CSE in any context²¹:

- Information about prevention of STIs and HIV, contraception, and the mechanics of fertility and reproduction
- Information about the role of pleasure, eroticism and satisfaction
- Discussion of gender differences and inequalities and human rights, and about the negative and positive effects of gender norms
- Information on the importance of responsibility and joint decision-making, and training in communication and negotiation skills
- Information on sexual and gender identity and sexual choice.

There is increasing evidence that CSE can act to increase knowledge, reduce risk-taking behaviours, improve negotiation skills, and reduce negative SRH outcomes. There is no single proscriptive method for delivering CSE to young people, and countries/programmes have tried a number of approaches including: family life education (FLE), population education, sex and relationships education, SRH education and life skills education, and dedicated sexuality education programmes. Irrespective of method, the underlying

18. WHO Adolescents: health risks and solutions Fact sheet N°345 Updated May 2014

19. WHO. Developing sexual health programmes: a framework for action 2010 p. 38

20. UNFPA SRH for All 2010 p. 20

21. UNFPA, 2003

principles of equity, cultural sensitivity, and gender mainstreaming are the key components for every CSE approach.

ENSURING EASE OF ACCESS AND QUALITY OF YOUTH-FRIENDLY SERVICES

Issues of access and quality affecting young people's uptake of SRH services encompass four areas:

- Physical access issues (including inconvenient location, service hours, inadequate supplies and equipment)
- Economic access issues (fees, cost of services, transport to reach clinics)
- Rules and restrictions of access, including policies inhibiting the ability for young people to seek confidential care regardless of gender or age
- Perceptions of 'youth friendliness'- that is to say, whether a health centre is considered to ensure privacy, provide non-judgmental and adequate care, and the perception that providers are sensitive to young people's needs.

It could be argued, however that the biggest barrier to increasing rates of SRH service uptake among young people is not accessibility, quality, or confidentiality, or even 'youth friendliness'; it is the awareness of and demand for services from young people themselves. Such demand is driven by peer/community norms as well as by individual characteristics. Changing norms of behaviour and creating demand for service use is a multi-sectoral goal, that is best achieved through the explicit involvement of young people themselves. Involving young people in the development, management, and governance

of tailored, up-to-date programmes is more likely to result in services that are acceptable and accessible for young people –it also moves young people away from being passive recipients of service delivery and towards people who are actively engaged in service uptake. .

FOCUSING ON PROGRAMME CONTENT

Programmes around the world deliver a wide range of services under the banner of SRHR. Such services are often defined by their thematic area (e.g. family planning or HIV prevention and care), or their target population (young people, migrants, people who sell sex). A comprehensive SRHR policy agenda and accompanying programme delivery will include services that both promote positive aspects of healthy sexuality and also address the more negative and predominantly disease-focused outcomes²². A review of these comprehensive service areas (by WHO and others) highlighted the following thematic areas under the umbrella of comprehensive SRHR programmes:

- comprehensive and effective sexuality education and counseling services
- reproductive health services including antenatal care, safe delivery and postnatal care
- contraceptive services including birth spacing and safe abortion
- infections and their sequelae (HIV, sexually transmitted infections, cancers, etc)
- female genital mutilation and other harmful practices
- sexual dysfunction

22. World Health Organisation, 2010. Developing sexual health programmes: a framework for action. WHO, WHO/RHR/HRP/10.22

- infertility and sub-fertility
- violence, stigma and discrimination related to gender inequality, sexual orientation and gender identity
- mental health issues related to sexual health (including sexual health needs of people with mental health concerns, and addressing the mental health needs of people with sexual health concerns)

Appendix 3 includes an overview of the content and focus of each of these services.

STRENGTHENING THE HEALTH SYSTEM FOR SRHR

As noted, the health sector has a vital role to play in improving SRHR, but it cannot and should not be acting alone. Achieving goals of SRHR at national and global levels, involves a variety of stakeholders across multiple sectors – ranging from law and judicial systems through to education services.

Nonetheless, the role of the health sector is vital – particularly for delivery of effective interventions for prevention and care. A strengthened health system requires robust mechanisms for managing financial flows, accountability, good governance, monitoring and evaluation, integration (both service and sector level), partnership-building, health information systems - all of which is contingent on strong leadership and the active participation of stakeholders on all levels of programme implementation²³.

The following overarching principles have been identified as being necessary at the national level for accelerated progress in SRH (based on those outlined by the WHO Reproductive Health Strategy in 2004):

GOOD GOVERNANCE AND ACCOUNTABILITY

Transparency and accountability must run throughout the lines of SRH policymaking, complete with clear goals, benchmarks, transparent monitoring processes, information sharing, and evaluations systems. Accountability has been defined by the former UN Special Rapporteur on the right to health as *“ensuring that health systems are improving, and the right to the highest attainable standard of health is being progressively realized, for all, including disadvantaged individuals, communities and populations”*.²⁴ Establishing and implementing frameworks of accountability enables governments and inter-governmental bodies to be held to account for the achievement of their global and local priorities and goals in SRHR.

There are currently few such accountability mechanisms in place at national level in most countries, but lessons could usefully be drawn from the experience of the Independent Expert Review Group (iERG) which reports regularly to the UN Secretary-General on the results and resources related to the Global Strategy for Women’s and Children’s Health, and the national accountability mechanisms put in place following the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) in 2001. The accountability framework has its origins in human rights bodies—namely, monitoring (based on a small number of health status and coverage indicators), transparent and participatory review, and remedy and action.²⁵ Others have proposed that national accountability mechanisms should include an emphasis on civic engagement to promote social

23. UNFPA SRH for All 2010 p. 21

24. Hunt P and Backman G (2008). Health Systems and the Right to the Highest Attainable Standard of Health. *Health and Human Rights*, 10(1), pp. 81-92.

25. Every woman, every child: from commitments to action: the first report of the independent Expert Review Group (iERG) on Information and Accountability for Women’s and Children’s Health. WHO, 2012. http://www.who.int/woman_child_accountability/iERG/reports/2012/iERG_report_low_resolution.pdf?ua=1

accountability.²⁶The inclusion of civil society, and particularly members of affected communities, has promoted increased participation, greater transparency, and has ensured that governments are held to account for their commitments.

MEASURING OUTPUTS: MONITORING, EVALUATION, AND SETTING KEY INDICATORS FOR PROGRESS

Good management of public resources and funds allocated for SRH requires constant monitoring and evaluation processes using carefully defined indicators, particularly if a system is undergoing major reforms. In order to establish the parameters, a clear plan must be set out containing targets, goals, and carefully developed indicators, accompanied by strong baseline data. Indicators should aim to disaggregate data by sex, age, socioeconomic and marital status. Proxies may have to be developed in order to measure outcomes harder to quantify, such as barriers to access and use of services. Special emphasis should be placed on not simply looking at basic, direct outcomes and indicators but also the indirect social determinants of sexual and reproductive (ill) health. A plan for general health-system evaluation should be developed, with an aim to feedback into monitoring systems – thus improving the flexibility and responsiveness of systems.²⁷

SUPPORTIVE LEGISLATIVE FRAMEWORKS

National laws can have an impact on SRH, both positively and negatively. When countries have laws that permit comprehensive sexuality education or ensure equitable access

to services, SRH outcomes are likely to be impacted positively. By contrast, laws that restrict service access or criminalise some consensual sexual activities may prevent individuals from realizing their SRH goals.

As noted, China has a comprehensive set of laws in place that promote and protect citizens to achieve their SRH goals. Nonetheless, as in every country, there are both gaps in the legal framework and, in contrast, punitive laws present which may act to hinder people from achieving their SRH goals – for example those laws which criminalise STI transmission. It is not within the remit of this report to fully analyse the legal framework underlying SRH in China, but simply to emphasize that a supportive legal and policy environment is a necessary prerequisite for enabling citizens and programmes alike to fully achieve their SRH goals.

FINANCING

A good financial scheme for SRH should aim to foster and maintain good quality, transparent, and economically sustainable reproductive and sexual health services. Depending on the context, governments should look to direct and coordinate financing with external donors or regulate private sector companies to deliver services (such as many of the European cases featured in this report). Measures to improve the management of health-sector financing, with particular relevance to China²⁸, could include better targeting of public funds (evidence-based) and monitoring their use, rather than simply increasing the budget.

Most SRH services fall under the category of preventative and primary healthcare

26. Flores W. Accountability and Monitoring in Health Initiative, Open Society Foundations (2011). Community monitoring for accountability in health: review of literature.

27. Much like the ones discussed in the case studies on the Netherlands and Sweden

28. Shanlian Hu, et al. Health System Reform in China 6: Reform of how health care is paid for in China: challenges and opportunities. The Lancet (2008), 74

interventions. UNFPA notes that SRH goods and services have been most successfully taken up when integrated as part of a primary health care package under a universal health insurance scheme, as in the case of Thailand and the EU case studies covered in this document. When determining the inclusion and regulations surrounding coverage, it is essential to determine the core components of SRH service citizens are entitled to and what may be included in stages or relegated to private-sector provision, in order to keep public costs of universal health insurance down. In order to do this, interventions must be assessed for effectiveness (both in terms of improving health outcomes and resource-effectiveness), costs, and feasibility in a variety of settings²⁹.

BUILDING PARTNERSHIPS

Improving SRHR means bringing together a variety of stakeholders across different sectors – including, government, bilateral and multilateral agencies, professional associations and research institutions, private sector partners, CSOs. Coordination, communication and collaboration among these stakeholders provide an opportunity for the creation of a broad consensus on the scope and direction of policy, constructive collaboration, greater resource mobilization and efficiency, and greater accountability on commitments made.

SERVICE AND SYSTEM-WIDE INTEGRATION

Integrated service delivery has been approached through a number of different models, ranging from provider level integration (one provider offering many services), facility level (many services offered at the same site) and through to programme and policy level integration. The evidence base for the effectiveness of different models of delivering integrated services is somewhat weak and highly context dependent³⁰. Nonetheless, there is some indication that integrated services increase levels of client satisfaction, but less evidence on whether use of services actually increases. A systematic review of models of integration and the impact on a number of variables concluded that integrated services (however delivered) may not be as effective as strengthening cross-referral patterns and systems³¹. Nonetheless, for perceived reasons of efficiency and effectiveness there is a strong push towards the provision of integrated services in most countries.

This first section of the report has outlined the key principles underlying comprehensive SRHR policies and programmes, and has highlighted some of the main aspects for strengthened service delivery of comprehensive programmes.

In the next section of the report we review how a number of countries have addressed comprehensive SRHR, before analyzing lessons learnt for China (in section 3).

29. Follow up to the ICPD 2014 p. 151

30. Church K, de Koning K, Martin-Hilber A, Ormel H, Hawkes S. Integrating Sexual Health Services into Primary Care: An Overview of Health Systems Issues and Challenges in Developing Countries. *International Journal of Sexual Health*, 2010;22:131-143.

31. Church and Mayehw



II. CASE STUDIES

RATIONALE FOR CASE STUDY SELECTION

The case studies selected have approached SRH promotion and related health sector reform implementation differently according to their respective historical and socioeconomic contexts. All have successfully integrated, or attempted to integrate, sexual and reproductive health policy frameworks into their health systems. Even those that have not yet fully implemented these reforms have drafted comprehensive national (S) RH(R) ³² strategies.

Each grouping of case studies is accompanied by an overview of any SRH agreements, consensuses, protocols, and conventions in their respective Regions.

Each case below has been selected for the lessons to be gleaned from their successes. However, important lessons may also be learned from failures. In all thirteen cases included in this report, each country managed to come to a consensus about the need for an SRHR strategy, and what it should include. More than anything, this is an example of the results of intensive coordination and cooperation across all sectors affected by such policies. Unfortunately, such coordination can become hampered by political climate, a lack of communication between ministries and involved parties, public opinion, and a range of other factors. One prominent example might be the United States, which, while involved in SRHR promotion globally, faced an uphill struggle to develop a comprehensive SRHR strategy. The 'Title X Family Planning Programme' (formally known as Public Law

91-572) is currently the only federal grant programme in effect governing the provision of family planning and "related preventative health services"³³. While providing basic medical SRH services (excluding abortion, a polarizing and politicized issue in the country), it does not as yet cover the full range of SRHR services, nor does it extend access equally to all its citizens in need of these services. This in turn might be attributable to anything from systemic factors to ideological ones, but it is notable that despite an ongoing debate and calls for one, there is yet to be an accord resulting in a nation-wide framework for SRHR in the United States of America. In light of that, just as the cases in this report highlight good practices China may take into consideration when developing its own SRHR strategy, it is important to also review and assess the challenges and obstacles at both the development and implementation phases faced by countries that have failed to incorporate such frameworks – such an activity may help identify strategies for overcoming such challenges in the future.

EUROPEAN UNION

Netherlands

Case for inclusion:

Netherlands has been lauded for being a champion of SRHR worldwide, having listed the improvement of SRH globally as one of their main priorities for international cooperation.

32. Note: Some countries may refer to SRHR frameworks as solely 'Reproductive Health' national health strategies, but it is increasingly understood that such a narrow approach cannot address the drivers of SRHR outcomes, nor the range of the population's needs.

33. U.S. Department of Health and Human Services. Office of Population Affairs. "Title X: The National Family Planning Program". Updated May 2014. <<http://www.hhs.gov/opa/pdfs/title-x-national-family-planning-overview.pdf>>

SRHR are fully incorporated into the policy framework and operational systems of the health sector, as well as the education sector and in the public mindset at large. This case would be an excellent example of successful policy/service integration, and positive (SRH) indicators as a result of concerted efforts at all levels of the public sector (from policymakers to service providers) to provide client-oriented healthcare.

Sweden

Case for inclusion:

Similarly to the Netherlands, Sweden has a long history of a comprehensive and integrated health system, with the inclusion of Reproductive and Sexual health. Young people in particular have free access to youth-friendly services, the positive results of which can also be gleaned from Sweden's high performance with regard to youth SRH indicators. Their general SRH indicators, in fact, are among the best in the world, and measures are being taken to address any existing gaps with regard to the needs of vulnerable groups, i.e. immigrants and MSM.

Spain

Case for inclusion:

In 2012, Spain's Ministry of Health, Social Services, and Equality drafted a National Strategy for Sexual and Reproductive health. Spain already has several policies within its existing body of legislation to address women's rights issues (including equality, GBV), HIV/AIDS, and service quality and integration, as well as an Organic Law on SRH and voluntary reproduction and voluntary abortion (2010)³⁴, but the ministry saw a

need for a comprehensive, cohesive strategy to address unmet SRH needs in Spain, and improve services generally.

United Kingdom

Case for Inclusion:

Until recently, the United Kingdom had some of the worst indicators for adolescent pregnancy and STI prevalence rates (with particular regard to Chlamydia) in the EU region. However, after zeroing in on the social determinants of these negative outcomes, the UK made sustained efforts through national SRH campaigns (and amending policy) particularly targeted at young people to promote safer sex and provide better screening and access to contraceptives. These programmes proved to be a massive success, and addressing young people's (health) issues as a whole have been made into a national policy priority. In terms of broader SRH policy scope, the UK has integrated SRH into its general body of public health legislation, recognizing SRH as part of the package for primary health care- however, notions of what needs to be explicitly included and covered (such as making family planning services more accessible to men as well as women) have continued to expand over time.

SUB-SAHARAN AFRICA

African Union (Maputo Protocol, CARRMA, African Youth Charter)

Case for inclusion:

Although a regional consensus is yet to develop in any other regions, the African Union (in collaboration with UNFPA and the African Regional Office of the International

34. Estrategia Nacional para Salud Sexual y Reproductiva. Ministerio de Sanidad, Servicios Sociales e Igualdad (2012).

Planned Parenthood Federation) convened in 2005-2006 to draft and ratify a regional SRH policy framework, in order to encourage making SRH a matter of priority (i.e. by mainstreaming SRH services within primary health care policy) among member states.³⁵

South Africa

Case for inclusion:

Over the past decade, South Africa has developed one of the most inclusive, integrated, and arguably progressive SRH policy frameworks in the African region. Additionally, as another of the large BRICS countries, including South Africa as a case study example might be of particular interest to Chinese policymakers.

Ethiopia

Case for inclusion:

Ethiopia recently developed a comprehensive Reproductive Health Strategy (2006–2015). The strategy encompasses six priority areas in line with those of the ICPD: social and cultural determinants of women’s reproductive health, FP, MCH, HIV/AIDS; young people’s SRH, and reproductive cancers. While it has yet to meet many of the difficult challenges presented by the gaps and social/economic obstacles to good SRH outcomes, the broad scope and thorough approach of this strategy sets a crucial foundation for future progress.

Kenya

Case for inclusion:

As of 2007, Kenya’s Ministry of health approved the first National Reproductive Health Policy framework (for 2009-2015), intended to encompass all aspects of RH services, with an aim to provide “equitable, efficient, and effective delivery of high-quality reproductive health services throughout the country”. Developed in conjunction with USAID, the document (similarly to Ethiopia) proposes a framework where key populations and issues are targeted, and cross-sectoral strategies, good management and accountability practices, and sustainability are a priority.

LATIN AMERICA

Brazil

Case for inclusion:

As one of the BRICS countries, as well as a developing (middle income) country with a large population size, Chinese partners might be particularly interested in reviewing Brazil’s approach to population health and SRH. Brazil’s case is a strong one for inclusion for this review, as they (albeit not uniformly, and with some problems at the implementation level) made the transition from viewing family planning from a population control perspective to a more comprehensive SRH strategy based on individual choice and needs. Brazil’s SRH policies are currently included within the Programa for Integral Attention to Women’s Health.³⁶

35. Refer to: Sexual and Reproductive Health: Continental Policy Framework. African Union Commission (2006).

36. Refer to: Programa de Atenção Integral à Saúde da Mulher: Princípios e Diretrizes. Ministério da Saúde (2004).

Mexico

Case for inclusion:

Similarly to Brazil, Mexico is also a large, populous country with urban/rural and ethnic minority populations comparable to one of China's scale. Also like Brazil, Mexico went from being concerned mostly with demographic transitions and its fertility rates to espousing the broad, rights-based approach to SRH put forward at the ICPD in 1994, and thus becoming more concerned with improving its maternal health/adolescent SRH indicators, as well as improving access to and quality of services. Mexico's Action Plan for Reproductive Health, drafted in 2001, outlines their new strategy in this regard, and RH policy is included within its broader National Health Programme.

Argentina

Case for inclusion:

Argentina is noted for having a comprehensive, integrated, system-wide approach to SRH service provision, the legislation and policy documents of which are firmly embedded in a rights and client-oriented language based on the freedom of choice of all individuals with regard to their sexual and reproductive autonomy. The bulk of these policies and implementation measures are encapsulated in the National Program of Reproductive Health and Responsible Procreation (2002). Moreover, the state has prioritized the needs of young people, started with the nationally-implemented program for Comprehensive Sexual Education (National Law No. 26.150).

ASIA PACIFIC

India

Case for inclusion:

Another BRICS case study, India drafted its new, integrated Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) as recent as last year (2013). India's sexual and reproductive health policy agenda falls under the National Rural Health Mission, where addressing maternal mortality and child survival were highlighted as top priorities. Despite considerable progress, upon revision of the latest data and trends pertaining to MCH, India's government recognised the need to address all aspects relating to SRH across the life course and sections of the population if it intended to reach its goals. The resulting document (the embodiment of the latest NRHM programme) undertakes the monumental task of integrating SRH services on all levels of governance as well as a strategic implementation, monitoring, and evaluation plan to ensure access to reproductive and sexual health to all citizens of the world's second-most populous country.

Cambodia

Case for inclusion:

Cambodia's National Reproductive Health Program was revised most recently in 2008³⁷. This document details its aims to 'ensure an effective and coordinated response to reproductive and sexual health needs in the country', developed along the principles of:

37. See National Strategy for Reproductive and Sexual Health in Cambodia: 2006-2010 (Revised version). Ministry of Health (2008).

human rights and empowerment; gender equity; multisectoral partnerships, linkages, and community involvement; and evidence-based programming. The document itself covers the full spectrum of SRHR issues advocated by countries party to the ICPD resolution. Its slow and uneven pace with regard to meeting its MDG targets (especially MDG 5) may well be the force behind its renewed commitment to ensuring access to SRH services at the policy level.

Thailand

Case for inclusion:

In 1997, Thailand inaugurated their National Reproductive Health Policy (strategy). It focused on issues ranging from FP, MCH, HIV/AIDS, Sex Education³⁸, Adolescent and Elderly Reproductive Health. Thailand's reproductive health policy framework still has a way to go before it is considered comprehensive (namely its need to include unmarried young people and their rights to access to quality SRH services), however the country's RH programmes have been success stories in terms of improving the SRH indicators targeted (for example, large reductions in MMR, IMR, HIV/AIDS contraction rates), and in terms of integrating family planning services into the national public health service system. In fact, although access at the implementation level (and at the policy level where it concerns unmarried persons) remains uneven, reproductive health services are included in the primary health care package covered by the national universal health care programme.

38. Markedly not sex-positive

EUROPEAN UNION

Regional Overview

The total population of the UNECE region amounted to 1.24 billion people in 2010 (compared to 1.18 billion in 2000). Growth has slowed, at an average of 0.5% over that decade, and is projected to slow down further to a rate of 0.05% in the 2030-2050 period, particularly in Western European countries. Consequently, the proportion of the population aged 65 and over is growing, and expected to account for roughly 20% of the total population by 2030³⁹, making ageing an issue of priority among policymakers across the region. As of the 1990s, the UNECE region has also seen a major influx of international migration, which has implications for policymakers both in the areas of economic policy and social integration, but also demography, health, and particularly SRH where vulnerable migrant groups are concerned. Life expectancy at birth is generally high, but once the differences between Eastern and Western European states are accounted for, marked disparities are apparent. Infant mortality has remained consistently low in the region- with 23 member countries reporting less than 5 deaths per thousand live births in 2010. However, while negative sexual health outcomes of earlier age groups and maternal and child mortality levels have declined or remained low, the incidence of reproductive cancers like breast cancer and cervical cancer was reported to be much higher (cited to be the result of a longer lifespan and improved detection and diagnostic programmes)⁴⁰.

The UNECE region is characterized by its progressive approach and generally good performance where promoting and providing

policy support towards gender equality and sexual and reproductive health and rights are concerned. Comprehensive sexual and reproductive health policies that give people autonomy over their reproductive health have been adopted widely by countries in the region, particularly with the advent of the ICPD and the EUs recent re-commitment to its agenda. Countries in the EU also emphasize the importance of regional cooperation on matters related to the ICPD, particularly in the areas of sustainable development, best practice-sharing, and health data management.⁴¹ Measures have been taken across the region to enlarge the range of services offered, as well as safeguards for quality, and to ensure universal accessibility. However, CSE is still lacking in many countries of the EU, both on the policy and practical levels⁴².

Regional Protocols, Calls to Action, and Commitments

- 1979 International Convention on Elimination of All forms of Discrimination against Women (CEDAW).
- 1993 United Nations World Conference on Human Rights. (Vienna 1993)
- 1994 UN International Conference on Population and Development. (ICPD, Cairo) (and All follow-up Plans of Action, i.e. ICPD +5, +10, +15, Follow-up post-2014)
- 2013 Motion for Parliamentary Resolution (Council of the European Union) (Call for a regional strategy on SRH, currently still in progress)

39.UNECE report 2013 p. 6

40.UNECE report 2013 p. 5

41.UNECE report 2013 p. xii

42.UNECE report 2013 p. xii

NETHERLANDS

Indicators

Population Size (in thousands) (2012): 16 714
p.c. GDP (2011) : 50 215
% Urban population (2012): 83.6
% Population under 15 (2012): 17
% Population over 60+ (2012): 21 (M), 24 (W)
Annual population growth rate (2010-2015): 0.3
Total fertility rate (2010-2015): 1.79
Adolescent fertility rate (2010-2015): 4.3/1000
Sex ratio (women per 100 men) (2012): 101
Maternal Mortality rate (2010): est. 6 (per 100,000l.b.)
CI 95 [4-7]
Infant mortality rate (2010-2015): Total 4 /1000;
Under- 5 mortality rate: 5 /1000
Contraceptive Prevalence rate 18-45: (2008): any
method: 69% modern methods: 67%
Proportion of births attended by a skilled health
professional: 100 (1998)
Source: (UN Stats)

Background

The Netherlands is an outstanding example with regard to SRH policy and programming; although the rapidly ageing population is increasingly the country's top public health priority⁴³, percentages relating to teenage pregnancy (4.3 per 1000 in 2007) and abortion (8.6 per 1000 women of reproductive age in 2007)⁴⁴, as well as STI transmissions are among the lowest in the world⁴⁵. In 2007 it was estimated that there were 3.2 neonatal deaths per 1000 live births, an average which has been decreasing over time⁴⁶. The country is also notable for being a strong advocate for SRHR internationally. The Netherlands groups all aspects of and issues relating to sexual and

reproductive health (and rights) under the term 'sexual health', which encapsulates its general attitude and its stance as a leader in SRHR promotion globally.

Current Scope

The Netherlands' has a decentralized health system with a strong focus on patient rights⁴⁷, where public health services fall under the responsibility of municipal governments, and individuals have a full range of options between high-quality private and public service providers⁴⁸. The municipal government is also responsible for health promotion in school and prevention programmes for high-risk groups, but this is a task also shared by the STD Foundation⁴⁹. Schools at the community level are moreover expected to integrate CSE into their curriculae, although this is not required by law.⁵⁰

Family planning is fully integrated into the primary healthcare package, as are most of the services listed in the introductory section of this report⁵¹. Emergency contraception, for instance, is available over the counter⁵², as are most other popular reversible methods like the combined oral contraceptive and IUDs, all of which are immediately made reimbursable for women less than 21 years of age, along with any services to do with sexual dysfunction, handicap, identity, or chronic illness⁵³. At the SRH primary healthcare, general practitioners provide most but not all services; most contraceptives, first-line infertility and STI/HIV diagnosis and treatment, and abortions

43. Health Systems in Transition Netherlands p. 1

44. RNG p. 17

45. Rutgers Nisso Groep p. 3

46. Health Systems in Transition p. 10

47. Ibid., p. 36

48. Ibid., p. 144

49. 65A Hardon / Reproductive Health Matters 2003;11(21):59-73

50. HSIT p. 66, Rutgers Nisso Groep p. 7

51. Refer to: "What Makes a Comprehensive SRH Agenda: Comprehensive SRH Service Provision" section of this report

52. RNG p. 12

53. RNG p. 40

(up until 24 weeks of gestation) fall under the list of services available. Infertility treatment in particular is regulated by the Netherlands Association for Obstetrics and Gynaecology, insurance and hospital guidelines. National policy stipulates that no more than three IVF treatments may be covered by health insurance companies or the Zickenfonds⁵⁴. Preventative infant and child-health care is managed by separate child health centres (established a century ago). Maternal healthcare, meanwhile, is for the most part covered by the highly developed and efficient Dutch midwifery services⁵⁵, including robust referral systems, national clinical guidelines categorizing high, medium, and low risk pregnancies and a strong promotion of home delivery in order to de-medicalize pregnancy⁵⁶. The success of this programme is evident in the low (and ever-decreasing) perinatal and maternal mortality rates. Dutch midwives also deal with the medico-technical aspects of sexuality problems. For other gaps in primary healthcare delivery, the Dutch government subsidizes a large number of RH-care agencies,⁵⁷ including Transact, a national organisation that focuses on sexual violence (although this has recently been more mainstreamed) and gender-related SRH issues. Transact further aids the process of gender-mainstreaming in the health sector by conducting gender-sensitization training programmes for health workers.⁵⁸ Finally, young people and

other vulnerable populations (particularly the Netherlands' share of immigrants and refugees) are paid special attention to; the former in particular enjoy low-threshold, youth-friendly services, often at specialized youth centres run by Rutgers, or rutgershuisen.⁵⁹

Health Systems Management for SRH

The Netherlands' model for healthcare provision is one defined by its current health financing policies. Despite a relatively low percentage of government expenditure devoted to health (8.9% GDP spent in 2007), it has been used efficiently enough to satisfy the needs of the population⁶⁰. The Dutch approach to governing the health system can be said to be oriented around four key concepts: consumer choice, finances, provision of high-quality care, and adaptability.⁶¹ As of 2003, the Dutch health system is currently carefully monitored and regulated with regard to cost-control⁶², with the aim to ensure equity of access to basic goods and services.⁶³ However, while the government exercises control over health care supply, expenditure limits, insurance reimbursement policies, and a compulsory national insurance scheme⁶⁴, the system innovatively combines both private and public sector providers and insurers via managed competition, and introduces market mechanisms into healthcare⁶⁵.

54.HSIt .p 68

55.HSIT p. 62

56.HSIT p. 67

57.HSIT. P. 62

58.HSIT p. 69

59.RNG p. 40

60.HSIT p. xxix

61.Asbroek et al 2004 p. 1

62.A question of Demand reforms in HC policy p. 12

63.HSIT p. 61

64.Ibid., p. 61

65.Ibid., p xxiv

In the wake of the health sector reforms of the early 2000's, the Dutch Health Care Performance Report (DH CPR) was developed in 2006 in collaboration with the OECD as a monitoring and evaluation tool. This system-wide evaluation includes 125 performance indicators and focuses on quality of care, access and affordability, and sustainability. The selection of indicators involves discussion between researchers and health policymakers, and overseen by the Ministry of Health. Quality norms, however, are usually set by healthcare providers themselves.⁶⁶The report also adds descriptive context to the indicators, including trends over time, variations between providers, and international comparisons⁶⁷. Finally, the DH CPR conducts a meta-evaluation to highlight gaps and suggest further improvements for the evaluation system itself. The report both serves as an accountability measure as well as a tool for strategic decision making, informing policymakers about the performance of the entire health sector (including care, cure, prevention, and social services)⁶⁸.

Recent Reforms

- Decentralisation of healthcare system, 2003.
- Introduction of a single compulsory health insurance scheme, 2006.
- New measures for health system analysis and strengthening (i.e. development of the Dutch Health Care Performance Report in 2006)
- Resumption of funding Rutgers-run youth-friendly service facilities (also known as rutgershuisen)

Highlights of Case Study

- Decentralized model of healthcare, where health service management is delegated to the lowest level of governance, but cost-control still overseen by national government.
- Carefully regulated mix of private and public service provision, subsidized or entirely covered by the universal compulsory health insurance scheme
- Emphasis on individuals taking responsibility for their SRH needs, through education and special measures to make goods and services as easily to access as possible at the primary healthcare level.

Current National Priorities

- Further efforts to decentralize healthcare
- Focus on updating services and ensuring access for emerging vulnerable groups (e.g. immigrant and refugee families).

66. EU health System Evaluation Report Questionnaire: Netherlands p. 3

67. EU Health System Evaluation Report Questionnaire: Netherlands p. 2

68. Asbroek et al 2004

SWEDEN

Indicators

Population Size (in thousands) (2012): 9, 449
p.c. GDP (2011): 57 134
% Urban population (2012): 85.4
% Population under 15 (2012): 17
% Population over 60+ (2012): 24 (M), 27 (W)
Annual population growth rate (2010-2015): 0.6
Total fertility rate (2010-2015): 1.93
Adolescent fertility rate (2010-2015): 6.5/1000
Sex ratio (women per 100 men) (2012): 101
Maternal Mortality rate (2010): est. 4 (per 100,000l.b.)
CI 95 [2-7]
Infant mortality rate (2010-2015): Total 3/1000; Under 5 mortality rate: 3/1000
Contraceptive Prevalence rate 18-44: (1996): any method: 75% modern methods: 65%
Source: (UN Stats)
Unmet Need: (UNDESA)

Background

Sweden is renowned for its excellent performance in public health (including SRH), particularly in health sector management and ensuring access to a cost-effective, high standard of care for all citizens, while prioritizing reaching their most vulnerable populations. The Swedish National Institute of Public Health ensures that the main objective and standards set out by national public health policies are met, namely, with the aim to “create social conditions that with ensure good health, on equal terms, for the entire population”⁶⁹. One of the 11 public health objectives outlined by the Swedish National Institute of Public Health is explicitly ensuring and improving Sexual and Reproductive Health. SRH Health Promotion programmes in Sweden are also of a high standard. Unlike the Netherlands, CSE is a compulsory part

of the primary school curriculum (managed by the Swedish Association for Sexuality Education, or RSFU)⁷⁰. Free, accessible, and confidential (i.e. youth-friendly) clinics are also available to young people across the country, and birth control is freely available to adolescents without the consent of their parents. As of 2012, Sweden and Finland had the lowest rates of HIV/AIDS prevalence in Europe (although rising incidence of some STIs including Chlamydia and syphilis has been reported among adolescents).⁷¹

Maternal health care was integrated into the health system as early as the 1930s, although a full range of contraceptive services were not made available to women through this department until the 1960s, and information on STIs and HIV was incorporated into the service package in the 1980s. Sweden boasts an extremely strong midwifery programme⁷²; in fact, midwives are accountable for nearly 80% of SRH services, including screening for cervical cancer.⁷³ Midwives are at the centre of maternal and child healthcare and family planning services (including contraceptive provision) at the primary healthcare level. Nearly all women in the population attend the nationally regulated antenatal programme, and prospective fathers are encouraged to take part in parenthood-preparation services. Significantly, there are no private clinics for delivery care.

Current Scope

The Swedish system, like most of the other cases featured in this report, determined that the best approach to SRH was to align services with specific needs across the lifespan.

69. European Observatory on Health and Policies Health Systems in Transition Series. Sweden: Health System Review. 14:5 (2012)p. 10

70. Guttmacher Young People: Sweden p. 30

71. p. 14 HSIT Sweden

72. Sweden Factsheet: Health in Sweden p.3

73. Guttmacher p. 30

Services include: wellness, primary care, medical and specialty care, and RH. Sweden's primary healthcare system's greatest strengths lie in its maternal health services (almost entirely spearheaded by their midwifery programme) and child health, as mentioned above. Services for children are offered by Child Health Services (including advice for mothers about breastfeeding and nutrition, as well as immunization⁷⁴). The general immunization programme for children is free of charge, and has included immunization against the human papilloma virus since 2010 for girls aged 10-12.⁷⁵ Public health services are all easily accessible and free of charge, and staff must be well-trained up to strict national standards.

Contraceptives are freely available without age restrictions, and the country is known for taking a particularly youth-friendly approach to SRH, recognizing that the attitudes towards SRH formed in adolescence bear consequences throughout the life cycle⁷⁶, and that adolescents have a right to make decisions about their sexual and reproductive health⁷⁷. A few youth clinics are run by NGOs, offering counseling for health, social, and psychological problems (with a focus on RSHR)⁷⁸, but most SRH services for young people are also fully integrated into primary healthcare clinics' service packages⁷⁹. Many county councils also have specialized units for HIV/AIDS prevention, offering information on risk behaviour and safe-sex practices⁸⁰.

Pregnancies are carefully categorized under high-risk, medium-risk, and low-risk

categories, as in the Netherlands, in order to effectively monitor pregnant women and the possible need for medical intervention or additional care during pregnancy (particularly notable for singling out socially disadvantaged women at risk of violence)⁸¹. Abortions are not typically performed in public primary healthcare facilities, but strong referral systems exist to direct patients in need of such services to independent providers.

Health Systems Management for SRH

As is the case throughout the developed world, Sweden's health care system is in a constant state of reform as governments seek to improve quality and access while controlling costs. Broadly, the focus of reform in recent years has been increasing the private sector's role in delivering universally accessible health care (particularly in primary care and pharmacy services), increasing patient choice and competition among providers in primary care, a greater focus on comparisons of indicators of quality and efficiency, improvements to care coordination, and specialization and concentration of hospital services. In spite of this continuous reform process, many of the core health policy characteristics of the Swedish model have remained constant since at least the early 1990s, if not much longer.

In 2009, healthcare expenditure accounted for 9.9% of the GDP. Healthcare is almost entirely tax-driven in Sweden. Nearly 80% of all health expenditures are public, largely funded by municipal councils⁸², while an additional

74.Guttmacher p. 30

75.HSiT p. 14

76.Guttmacher p. 29

77.Guttmacher p. 28

78.Guttmacher p. 30

79.Guttmacher p. 29

80.Guttmacher p. 26

81.HSiT Sweden p. 14

82.Lessons for Canada p. 18

17% is private expenditure, based on user charges⁸³. Government funds, meanwhile, account for 2% of total expenditures⁸⁴. Special emphasis is placed on making sure treatment is cost-effective in order to be accessible to the whole of the population based on need, rather than ability to pay⁸⁵.

Sweden's central pillar for health sector governance is its localism where management is concerned⁸⁶. The national Ministry of Health and Social Affairs is responsible for overall healthcare policy formulation and oversight, but service delivery, regulation, and funding is left to the authority of municipal councils (to an even greater extent than the Netherlands). Both public and privately-owned healthcare facilities are available to the public, but these are all generally publicly funded or covered by national health insurance to some extent⁸⁷. Eight government agencies can be said to be directly involved in determining health policy in Sweden: the National Board of Health and Welfare, the Medical Responsibility Board (HSAN), the Swedish Council on Technology Assessment in Health Care, the Medical Products Agency (MPA), the Dental and Pharmaceutical Benefits Agency (TLV), the Swedish Agency for Health and Care Services Analysis, the Swedish Social Insurance Agency and the National Institute for Public Health- the latter of which is primarily responsible for SRH policy, as most of it falls under the category of public health concerns. Through their coordinated efforts, these government bodies develop a clear health policy

framework for Sweden, including SRH services at appropriate levels of care, and set the national standards that guide municipal level governments.

The Swedish policy development process is necessarily evidence-based to determine the effectiveness of interventions, and healthcare providers must hold up nationally approved standards of knowledge and practice.⁸⁸ The National Institute of Public Health is responsible for cross-sectoral follow-up⁸⁹. Evaluations are regularly conducted across regions to compare performance indicators vis a vis reaching national targets⁹⁰, and include indicators to assess quality of care, i.e. safety, accessibility, whether or not it is evidence-based, patient centredness, and efficiency⁹¹. Moreover, national registers offer a good set of databases for further analysis and evaluation. In terms of accountability measures, the National Patient Survey and the Health Care Barometer provide indexes for measuring patient satisfaction with the quality of healthcare⁹². Given that Sweden's healthcare system is nearly entirely tax-funded, increasing transparency is an important component to ensuring the sustainability of the health sector, and monitoring where the highest demand is coming from⁹³.

Recent Reforms

- Since 2005, there has been a new care guarantee in Sweden to improve patients' rights and equitable access to elective care⁹⁴

83.HSiT Sweden p. xix

84.Lessons for Canada p. 18

85.Sweden: Lessons for the UK p.1

86.Sweden: Healthcare lessons for Canada p. 1

87.Sweden's Healthcare System: Lessons for the United Kingdom p. 5

88.HSiT Sweden p. xviii

89.HSiT p. 31

90.HSPA p. 1

91.HSPA p. 4

92.Facts about Sweden: Healthcare p. 2

93.HSiT Sweden p. 138

94.HSiT Sweden p. xxi

- Increased transparency has also led to reforms across regions upon the identification of gaps in service and quality, as well as increased responsiveness towards needs of the population⁹⁵

Highlights of Case Study

- Sweden's Health care system is one characterized by careful delegation of authority to the lowest appropriate level of care, using a patient-centred, demand-based approach

- Sweden's openness and positive attitude towards SRH and sexuality issues has helped build a relatively sexual stigma-free society, which in turn should help keep uptake of SRH services about adolescents consistently high

- Strong, integrated primary healthcare service, optimal human resource utilization via midwifery training programme covering a full range of SRH issues.

Current National Priorities

- Increase efficiency of service provision and management on all levels (but ensure that capacity is adequate at the lowest level)

- Young People's health (and sexual and reproductive well-being in particular)

- Perhaps the only visible Achilles' heel in the otherwise world-class Swedish system is waiting times, which are fairly widely acknowledged to be a problem.

UNITED KINGDOM

Indicators

Population Size (in thousands) (2012): 62 798

p.c. GDP (2011): 38 918

% Urban population (2012): 79.7

% Population under 15 (2012): 17

% Population over 60+ (2012): 21 (M), 25 (W)

Annual population growth rate (2010-2015): 0.6

Total fertility rate (2010-2015): 1.87

Adolescent fertility rate (2010-2015): 29.7/1000

Sex ratio (women per 100 men) (2012): 103

Maternal Mortality rate (2010): 12 (per 100,000l.b.) CI 95 [10-14]

Infant mortality rate (2010-2015): 5/1000; Under -5 mortality rate: 6/1000

Contraceptive Prevalence rate 16-49 (2008/9): any method: 84% modern methods: 84%

Proportion of births attended by a skilled health professional: 99% (1998)

Source: (UN Stats)

Background

Relative to the other European case studies reviewed in this report, the United Kingdom faces a few more challenges in the area of Sexual and Reproductive Health; while its overall fertility rate is under replacement level, the adolescent fertility rate remains high (if not the highest) for European standards. The rate of abortion was reported to have increased by 50% between 1984 and 2005 (an estimated 180,000 performed in 2005)⁹⁶, which represents a clear unmet need for contraception, particularly among adolescents and young people. Moreover, marked inequalities in SRH exist across socioeconomic strata. For example, the Healthcare Commission estimated that the rate of conception among young women under the age of 18 in the 10% most deprived areas was four times higher than the 10% least deprived, and twice cases of cervical cancer

95.HSiT Sweden p. xxiii.

96.Healthcare Commission "Performing Better? A focus on sexual health services in England: Summary Report" 2007. p.4

were reported for these least-affluent areas as compared to the most affluent.⁹⁷ Ethnicity and age are also determinants of ill-sexual and reproductive health. Across the United Kingdom, STI and HIV prevalence is higher among individuals of Afro-Caribbean descent when compared to the baseline population, and young people between the ages of 16-24 are most at risk of contracting non-HIV STIs.⁹⁸ Negative SRH outcomes are estimated to cost the United Kingdom approximately GBP 700 million annually.⁹⁹

Despite these issues, successful campaigns targeted at addressing SRH concerns have served as stellar examples of the benefits of genuine political will and efficient health sector mobilization. Improving sexual ill-health was one of the top six priorities listed by the National Health Service (NHS) for the 2006-2007 period. The UK identified teenage pregnancy and STI contraction in particular as matters of national public health priority and duly implemented a ten-year Action Plan and prevention strategy (included youth-targeted awareness campaigns to promote safe sex practices) to address these. In 2011, the number of teenage conceptions was reported to be the lowest since records began in 1969, despite the estimated number of overall conceptions that year being the second-highest recorded since that time.¹⁰⁰

Current Scope

A Framework for Sexual Health Improvement in England (2013)

While this strategy was specifically developed for England rather than the wider UK context,

this recent addition to the UK's body of SRHR policy framework takes a comprehensive approach to setting up the evidence base for improving SRHR outcomes in the UK, and to provide the necessary support tools for all providers at the local level to ensure that the full range of SRHR services is accessible to all those in need of them, and are up to the highest standard of quality.¹⁰¹

The document iterates the need to take the life-course approach to SRHR. Importantly, moreover, it places emphasis on identifying the key drivers of poor SRHR outcomes in the country as a means to inform strategy.¹⁰² The document goes on to detail priority SRH concerns and how best to tackle these. Above all, the strategy stresses prevention measures as the most important interventions, and for all such measures to be based on carefully obtained scientific evidence and diligent monitoring and evaluation.

This framework, unlike the cases of the Netherlands and Sweden, explicitly provides a frame-by-frame breakdown of how to assess the SRHR situation in a country beyond just SRH outcomes; that is, by looking at the wider socioeconomic and behavioural drivers of these outcomes. Further, according to the specific needs arising from these circumstances, it details how to proceed in taking a localised, focused approach to addressing these issues, in this case by suggesting the formation of health and wellbeing boards and the need for new commissioning strategies¹⁰³.

97. Healthcare Commission "Performing Better? A focus on sexual health services in England: Summary Report" 2007. p.4

98. Healthcare Commission 2007.p.4

99. Healthcare Commission 2007.p.2

100. ONS. Teenage pregnancies at lowest level since records began. Conception Statistics, England and Wales, 2011 Release(2013)

101. Department of Health. 2013. A Framework for Sexual Health Improvement in England. London.

102. Department of Health 2013 p. 21

103. Ibid. p. 11

Previous SRHR Strategy

National strategy for sexual health and HIV (2001)

The Government has put into place a range of policies, guidance and national initiatives that focus on improving sexual health and reducing inequalities in health status regarding sexual health. Key among these was the National Strategy for Sexual Health and HIV (2001), developed by the Department of Health. Its mandate stated that

“Sexual health is an important part of physical and mental health. It is a key part of our identity as human beings, just as privacy, a family life and living free from discrimination, are our fundamental human rights. The essential elements of good sexual health are equitable relationships and sexual fulfilment, as well as access to information and services to avoid the risk of unintended pregnancy, illness or disease.”

The Strategy called for the comprehensive provision of contraceptive services and three levels of provision in both public and private healthcare settings. The Medical Foundation for AIDS and Sexual Health (MedFASH) later amended it to include: the prioritization of sexual health as a public health issue on the municipal, regional, and national levels; the need to build and foster partnerships; the need for a commission dedicated to improving sexual health; further investments in prevention measures for SRH ill-health; and mechanisms to ensure the delivery of modern sexual health services to the general population.¹⁰⁴ It also aimed to strengthen primary care service delivery and expand the role of nurses and community health-workers,

ensure that all healthcare providers upheld national standards and within networks with clear referral pathways, establish local multiagency groups to inform, implement, and monitor sexual health, and integrate HIV and other SRH services.¹⁰⁵ The Strategy was later retired in 2010 by the coalition government in power at the time, announcing that a new strategy would be developed to place patients squarely in the centre of the health decision-making process, stricter accountability measures, as well as to decentralise SRH service delivery, not unlike the Dutch and Swedish case studies discussed at length in this report.¹⁰⁶

Other Relevant Policies and Bodies

National Framework for Commissioning HIV, Sexual and Reproductive Health Services

Public Health England, in conjunction with partner agencies, is also developing an updated strategy for improving sexual health in the United Kingdom as a whole in 2013, providing guidance to local governments, NHS England, and clinical commissioning groups (CCGs) for effective commissioning of SRH services (including HIV) that meet the needs of the population. This does not include reproductive health, as it would in the case of the Netherlands, but this may be because maternal and child health has been much more successfully embedded in primary health care policy than sexual health services.¹⁰⁷

Teenage Pregnancy Strategy: Beyond 2010

A separate teenage pregnancy strategy was drafted by the Department of Health and the Department for children, schools, and families in 2010, part of the UK's MoH's concerted

104.FPA Factsheet Brief 2011 p. 4

105.Kinghorn, George. A sexual health and HIV strategy for England BMJ. 2001; 323(7307): 243

106.FPA Factsheet Brief 2011 p. 5

107.Public Health England. National Framework for HIV, Sexual and Reproductive Health Service Commissioning (Draft 2014 Final Version Forthcoming)

efforts to combat teenage pregnancy (i.e. young people in care, homeless, underachieving in school, children of teenage parents, certain ethnic groups, involved in crime, and living in areas with higher social deprivation)¹⁰⁸ Key factors to successful commissioning have been highlighted as: strategic leadership and accountability, use of local data to monitor progress, CSE implementation, and youth-friendly contraception and sexual health services. The document further highlights the need to intervene early, and to focus on particularly vulnerable groups of young people, as well as providing young people with necessary information and skills, and ensuring access to youth-friendly services.¹⁰⁹

Other Relevant Policies

- Public Service Agreement (PSA) on targets for sexual health 2000.
- Better Prevention, Better Services, Better Sexual Health Action Plan (2003)
- Independent Health Care National Minimum Standards
- The NHS in England: The Operating Framework for 2006
- Reaching Out: An Action Plan on Social Exclusion (with regard to teenage pregnancy)

Recent Reforms

- New strategy for an integrated, full-system approach to commissioning SRH/STI/HIV services (2014), developed by Public Health England
- National Strategy on SRH for Young People 'Positive for Youth (A new approach to cross-government policy for young people ages 13-19)', developed in 2011 in response to persistent problems with adolescent STI contraction and pregnancy rates.

Highlights

- Successful teenage pregnancy, STI, and HIV awareness campaigns
- Special attention given to addressing SRH disparities due to socioeconomic inequalities
- Despite strong centrally-planned National Health Service system and universal health coverage of SRH services, government still sees value in developing comprehensive policy and programme frameworks to address SRH issues

Current National Priorities

- STI, HIV, SRH service integration
- Prevention of new gonorrhoea infections
- Continue progress in lowering teenage (and general unintended) pregnancy rates
- Reducing the transmission of HIV and STIs, prevalence of undiagnosed HIV
- Reducing Stigma associated with HIV contraction

108.FPA factsheet teenage pregnancy Aug 2010

109.Her Majesty's Government Positive for Youth (A new approach to cross-government policy for young people ages 13-19) p. 55

SPAIN

Indicators

Population Size (in thousands) (2012): 46 772
p.c. GDP (2011) : 31 820
% Urban population (2012): 77.6
% Population under 15 (2012): 15
% Population over 60+ (2012): 20 (M), 25 (W)
Annual population growth rate (2010-2015): 0.6
Total fertility rate (2010-2015): 1.50
Adolescent fertility rate (2010-2015): 10.7/1000
Sex ratio (women per 100 men) (2012): 102
Maternal Mortality rate (2010): est. 6 (per 100,000l.b.)
CI 95 [4-7]
Infant mortality rate (2010-2015): Total 4/1000; Under 5 mortality rate: 4/1000
Contraceptive Prevalence rate 15-49 (2006): any method: 66% modern methods: 62%
Source: (UN Stats)
Unmet Need: 11.8% in 1995 (UNDESA)

Background

The most recent MMR and IMR rates for Spain, as well as their adolescent fertility rates, would seem to indicate relatively good performance where sexual and reproductive health is concerned. However, despite Sexual and Reproductive health performance indicators in Spain are not significantly worse than the average among developed EU countries, there have been sustained efforts to guarantee and protect SRH (with particular regard to women's rights in this respect), most recently culminating in the 2010 National Reproductive Health Strategy. Undoubtedly because of the country's history of unequal status of women, and particularly in the area of SRH during the Franco regime (1939-1975), Sexual and Reproductive Health policies in Spain are framed by a context of strong advocacy for gender equality and promoting women's rights to (reproductive and sexual) health and freedom from violence and discrimination. The substantial body of legislation on both gender equality issues as

well as SRH is the result of concerted efforts across government sectors and vocal health rights CSOs. Moreover, this is bolstered by the fact that Spain is also party to most if not all international protocols and conventions to improve access to health and freedom from gender discrimination.

The National Strategy on Sexual and Reproductive Health (ENSSR) was passed by the Inter-territorial council of the national health system (which include all the autonomous regions), following the quality criteria of the Ministry for Health, Social Policy and Equality (MSPSI, in its Spanish acronym) and the mandate of Spanish Organic Law 2/2010 on sexual and reproductive health and the voluntary interruption of pregnancy

Current Scope of SRH Policy Agenda

The National Strategy for Sexual and Reproductive Health Strategy

The current NRHS (2012) breaks down Reproductive and Sexual Health services respectively and sets forth guidelines for effectively and efficiently running these programmes, by regulating and imposing national standards for SRH health promotion, service delivery, training healthcare providers at all levels, and placing emphasis on good governance, research-based innovation, and good practices in transparency and accountability. The NRHS also describes institutional coordination as "a fundamental aspect to perform investigations, implement innovative processes in addition to knowing and sharing good practices between the different autonomous administrations, institutions and also between professionals"¹¹⁰ The document covers the full range of services under SRH (including priority issues for women across the life course such as contraception, abortion, same-sex marriage and the fight

110.NRHS 2010 p. 148

against gender-based violence), and makes a point to highlight both the rights to sexual health of the individual and the continued need to fight gender discrimination and gender based violence in Spain. The NRHS also calls for greater direct participation of citizens, and other key stakeholders and partners. The assessment process to be faced by the Strategy will be performed over three phases related to the structure, design and results arising from implementation of the Strategy across both the Central government and all Autonomous region governments.

Other Relevant Policies and Bodies

- Law 14/1986, General Health Law.
- Organic Law 10/1995 of the Penal Code, which criminalises violations of sexual freedom and identity
- Law 41/2002 which regulates the autonomy of patients and rights
- Law 16/2003 on the Cohesion and Quality of the National Health System, which determines the coordination and cooperation activities of public health authorities
- Law 44/2003 on the organisation of health professions.
- Law 30/2003 on measures to incorporate the evaluation of the impact of gender on the different types of regulation that the government draws up.
- Organic Law 1/2004, on Integral Protection Measures against Gender-based Violence.
- Law 13/2005, which modifies the Spanish Civil Code on the right to get married.
- Royal Decree Law 1030/2006, which establishes the National Health System's parameters for primary healthcare. Teenage care services refer to the promotion of healthy

behaviour regarding sexuality, avoidance of unwanted pregnancies and sexually transmitted diseases.

- Law 14/2006, on assisted techniques of human reproduction.
- Spanish Law 14/2007 on biomedical research regulations
- Organic Law 2/2010, on Sexual and Reproductive Health and the Voluntary Interruption of Pregnancy

Recent Reforms

- National Strategy on Sexual and Reproductive Health (2012)
- Law 2/2010 on sexual and reproductive health and the voluntary interruption of pregnancy. (2010)
- Law for Effective Gender Equality (2007)
- New Health Ministry regulations for the public funding of new contraception methods (2011)
- Strategy for Assistance at Normal Childbirth in the Spanish National Health Service (2008)
- Strategic Plan for Equal Opportunities (2008-2011)
- Multi- sector Plan to fight against HIV infection and AIDS (2008-2012)

Partnerships

FPFE (Spanish Family Planning Federation), The Centre for the Analysis and Health, Programme, the Federation of Midwives' Associations in Spain, Creación Positiva, Catholics for, the Right to Decide, Women for Health and Peace, the State Federation of Lesbians, Gays,, transsexuals and bisexuals

(FELGTB) , CESIDA network that brings together most of the national and international organization, bodies and institutions of the movement of associations that work on HIV/AIDS across Spain, Council for Women's Participation

Highlights of Case Study

- In a country doing relatively very well where SRH performance is concerned, the national government has made concerted efforts to ensure the protection of SRH rights, as well as embed Gender issues into the discussion.

- Comprehensive legislative body concerned with protection of SRH rights to access to quality services and freedom from discrimination

- Complementary National Reproductive Health Strategy used to unify these diverse laws and related government bodies and other national and international health partners for a cohesive approach to guaranteeing SRH.

Current National Priorities

- Addressing persisting issues in gender inequality

- Guaranteed Access to contraception.

- Adoption of a full life-cycle approach to SRH provision

- Effective sexual education as a cross-cutting issue in education

- Gender based violence (identifying and addressing causes)

- Addition of a comprehensive monitoring, evaluation, and financing scheme for the new National Strategy on Reproductive Health, as well as promotion of implementation across all Autonomous Regions.

SUB-SAHARAN AFRICA

Regional Overview

It is well-known that of all the developing regions, Sub-Saharan Africa is the least likely to reach its MDG targets by 2015, especially with regard to the health-related ones. Like Latin America and Asia-Pacific, the Sub-Saharan region is not uniform in its performance with regard to SRH (contrast the Ethiopian, Kenyan, and South African case studies in this report). In Western Africa, less than 10% of women were reported to use any modern method of contraceptive in 2009. Additionally, 1 in 22 women dies from maternal causes annually, as compared to 1 in 120 in Asia¹¹¹, and only 48% of births were attended by a skilled birth attendant.¹¹² Unmet need is the highest in the world, and young people, who comprise an ever-larger section of the population, are reported to have a prevalence of 1 in 20 for HIV/AIDS. Other long-standing issues include gender-based violence including female genital mutilation, of which adolescent girls are particularly at risk, along with HIV, due to persisting gender inequality in society at large.¹¹³

However, the African Union's continued commitments to SRH promotion and collaboration at the regional policy level is exemplary, offering hope for future progress, and their resulting policy documents offer excellent models for approaches to comprehensive SRH policy and service provision across countries in varying stages of development. In 2001, the AU member heads of state set a target to devote at least

15% of their country's respective budgets to improving the health sector.¹¹⁴ As of 2013, all member states have institutionalized SRHR, and 51 out of 52 states have drafted specific strategies to address their SRH priorities in the coming decade.¹¹⁵

Regional Protocols, Strategies, Conventions, Calls to Action, and Commitments

- 1979 International Convention on Elimination of All forms of Discrimination against Women (CEDAW).
- 1981 The African Charter on Human and People's Rights.
- 1993 United Nations World Conference on Human Rights. (Vienna 1993)
- 1994 UN International Conference on Population and Development. (ICPD, Cairo)
- 1995 Beijing Declaration and Platform for Action adopted at the Fourth World Conference on Women.
- 1990 African Charter on the Rights and Welfare of the Child.
- 2001 The Abuja Call for accelerated action towards Universal Access to STI/HIV/AIDS, Tuberculosis and Malaria services in Africa

111. UNFPA Country Profiles for Population and Reproductive health Policy Developments and Indicators 2009-2010 p. 15

112. WHO Leading the way p. 5

113. UNFPA 2010 p. 15

114. p. 18 ARROW report 2012

115. ICPD Beyond 2014: Africa Regional Report p. 77

- 2003 The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa or (the Maputo Women Protocol).

- 2004 The Solemn Declaration on Gender equality in Africa (SDGEA).

- 2006 Maputo Plan of Action on Sexual and Reproductive Health and Rights of operationalization of the Continental Policy Framework on Sexual and Reproductive Health and Rights.

- 2006 Brazzaville Commitment on Scaling Up Towards Universal Access

- 2007 The African Health Strategy (2007-2015).

- 2009 Campaign on Accelerated reduction of Maternal Mortality in Africa (CARMMA).

Regional and Sub-regional SRH policymaking/advocacy bodies

- African Union

- Common Market for Eastern and Southern Africa (COMESA)

- The East African Community (EAC)

- The Southern African Development Community (SADC)

- East, Central, and Southern African Health Community (ECSA)

SOUTH AFRICA

Indicators

Population Size (in thousands) (2012): 50 738

p.c. GDP (2011) : 8 090

% Urban population (2012): 62.4

% Population under 15 (2012): 30

% Population over 60+ (2012): 6 (M), 9 (W)

Annual population growth rate (2010-2015): 0.5

Total fertility rate (2010-2015): 2.38

Adolescent fertility rate (2010-2015): 50.4/1000

Sex ratio (women per 100 men) (2012): 102

Maternal Mortality rate (2010): est. 300 (per 100,000l. b.) CI 95 [150-500]

Infant mortality rate (2010-2015): Total 46 /1000;

Under 5 mortality rate: 64/1000

Contraceptive Prevalence rate 15-49 (2003/4): any method: 60% modern methods: 60%

Proportion of births attended by a skilled health professional: 82 (1996), 84.4 (1998), 91.2 (2003)

Source: (UN Stats)

Unmet Need: 13.8% in 2004 (UNDESA)

Background

South Africa is among the most-developed countries in the Sub-Saharan African region, and a strong member of the African Union. With a current fertility rate just above replacement level, a high contraceptive prevalence rate (relative to the rest of the region), and a very high proportion of births taking place in the care of skilled birth attendants (approx. 92% in 2009), South Africa is also not the worst-off in terms of SRH.¹¹⁶ However, challenges remain; the Maternal Mortality rate, central to the achievement of MDG 5, is still high (although it has been decreasing rapidly over time), and the HIV/AIDS prevalence rate still ranks among the highest in the world,¹¹⁷ itself a major determinant of maternal and child death due to mother-to-child HIV transmission. In fact, by 2009, South Africa was among the only

116. UNFPA and Population Reference Bureau. Country Profiles for Population and Reproductive Health: Policy Developments and Indicators for 2009-2010(2010).p. 94
117. UNFPA (2010).p. 94

countries worldwide that had experienced an increase in maternal and infant mortality since 1990 with regard to relative progress towards the achievement of MDGs 4 and 5.¹¹⁸ As a result, the Government of South Africa made huge investments in scaling up programmes for prevention of mother-to-child HIV transmission and HIV treatment for pregnant mothers.¹¹⁹ On a wider level, South Africa faces the need to address four ‘colliding epidemics’¹²⁰: HIV and Tuberculosis co-infection; chronic illness and mental health; injury and violence (including GBV); and maternal, neonatal, and child health- the interrelated nature of which requires a massive collaboration effort across all responsible government ministries and stakeholders.

Current Scope

National Department of Health’s framework for sexual and reproductive health and rights (Sexual and Reproductive Health and Rights: Fulfilling our commitments 2011-2021) (2011)

South Africa is notable in the Sub-Saharan African region for having a solidly progressive and open approach to SRHR. The National framework for SRHR begins by declaring that the main goal of the strategy is to provide equitable and non-discriminatory access to high-quality SRH information, education, treatment, care, and rehabilitation services, regardless of age, gender, relative socioeconomic status or sexual orientation (and with particular concern for reaching vulnerable populations). Moreover, it states that all South Africans have a right to express and enjoy their sexual and reproductive rights.

The Strategy defines comprehensive sexual and reproductive health and rights services as including all aspects of promoting a culture of sexual and reproductive rights, and all aspects of prevention, diagnosis, treatment and care in relation to sexual and reproductive health. The framework stresses the need to be evidence- and human rights- based, and in line with national policies, protocols and clinical guidelines, the latter of which should be updated in line with emerging evidence and good practice. It also establishes the following principles for maximum impact of service provision: strong and visible stewardship, integrated services at the district level, a human rights approach, a life cycle approach, meeting diverse needs, and care for the caregivers, and cross-sectoral collaboration¹²¹.

The framework commits to sexuality and relationship education, information and ideas as well as social mobilisation and community and mass media campaigns, to be initiated by government or in collaboration with partners, and designates service provision to be managed by district health systems, including those provided in communities and through mobile services, community health centres and district hospitals. Creating linkages, promoting integration where most strategically efficient is stated to be key to the success of the aims outlined in the document, as is careful performance evaluation.

In addition to the framework for service provision, the strategy identifies the essential steps for implementation, including: ensuring the necessary leadership, governance, financing, medical technologies and products,

118. Mayosi et al 2012 p. 2033

119. Mayosi et al 2012 p. 2033

120. Mayosi et al 2012 p. 2030

121. NRHS 2011

service delivery, effectively trained and skilled health service managers and providers (with the appropriate attitude and competencies), and strengthening the information base for planning, monitoring and evaluating community-based and health system interventions.

The Contraception & Fertility Planning Policy and Guidelines– policy framework, service delivery and clinical guidelines. (2012)

Prior to the National Department of Health's framework for sexual and reproductive health and rights, The Contraception and Fertility Planning Policy and Guidelines comprised the main body of policy covering sexual and reproductive health programming, guided by the National Family Planning programme. These guidelines, first developed in 2001, have recently been revised (in the wake of the HIV/AIDS crisis) to broaden the scope; for example, the revised strategy now includes the provision of emergency contraception as an essential component of primary care (under the recognition that avoiding unwanted pregnancy is also avoiding preventable maternal death via unsafe abortion and complications)¹²². Contraception services are provided free of charge in most public health facilities, but there is also allowance for public-private partnerships and private service provision.¹²³ Like the National Department of Health's framework for sexual and reproductive health and rights, special emphasis is placed on addressing the SRH needs of women at risk of and living with HIV/AIDS, as well as their partners, as well as the needs of sex workers, LGBT, migrants, women who are disabled or suffering from chronic conditions, and adolescents.

Other Relevant Policies and Bodies:

- 2007-2011 National Strategic Plan for HIV&AIDS and STIs
- Current 2012-2016 National Strategic Plan for HIV, STIs and TB (addition of Tuberculosis to address co-infection), as well as improved inter-governmental coordination¹²⁴
- The Parliamentary Joint Monitoring Committee on the Improvement of the Quality of Life and the Status of Women

Health Systems Management for SRH

The National Department of Health's framework for sexual and reproductive health and rights (Sexual and Reproductive Health and Rights: Fulfilling our commitments 2011-2021) (2011) aligns its proposed implementation plan for its SRH agenda with the WHO's proposed six building blocks of a well-functioning health care system¹²⁵:

- Leadership and governance: Including Political leadership, intersectoral collaboration, engagement with development partners and civil society, and accountability measures
- Financing: No concrete financial plan is outlined, however a call is made for resource allocation on state and provincial levels to reflect SRH needs
- Provision and management of medical technologies and products: package of essential sexual and reproductive health and rights services to be incorporated in the Essential Primary Care and Hospital Drugs lists.

122. Contraception and Family Planning Guidelines (2012 Revision)

123. UNFPA 2010 p. 2

124. p. 2 NCPi

125. National Department of Health (South Africa). Sexual and Reproductive Health and Rights: Fulfilling our commitments 2011-2021. (2012) p. 23

- Service delivery based at national, provincial and district levels of the health system based on continuity of care for an individual from a life-course based approach, ensuring effective, safe, quality services, accessibility, equitability, and availability to all who need them.

- Human resources: Capacity building through training, attitude and competencies

- Information, monitoring and evaluation for improving service quality : Information on the social and cultural determinants of sexual and reproductive health and changes in social norms and practices, Information on health system performance, Information on health status and health outcomes

As yet, however, no detailed plan of action or list of targets and outputs has been elaborated for rolling out the objectives set forth in this document, although it lays the groundwork for framing a more concrete implementation plan, and the establishment of three national committees on Maternal, Perinatal, and Child Mortality commissioned by the Ministry of Health could signal a step towards better programme and data management, and ultimately informed policy decision-making.¹²⁶

Highlights of Case Study

- Progressive and open approach towards SRHR provision- calls for freedom from discrimination of all kinds and the freedom to express and protect SRHR as desired, in line with the attitude set forth at the ICPD in 1994

- Multi-pronged approach to handling major causes of morbidity and mortality, recognizing their intrinsically linked natures, and accounting for it by calling for collaboration across all sectors.

Current National Priorities

- Prevention of new infections of HIV/AIDS and Tuberculosis (as well as incidence and mortality due to preventable NCDs, violence, maternal and child ill-health, and mother-to-child transmission)

- Integration of effective primary healthcare services

- Improvement of monitoring and evaluation instruments and processes

- Evidence-based policy-making based on rigorous scientific research.

126. Mayosi et al 2012 p. 2033

KENYA

Indicators

Population Size (in thousands) (2012): 42 749
p.c. GDP (2011): 819
% Urban population (2012): 24.4
% Population under 15 (2012): 42
% Population over 60+ (2012): 4 (M), 5 (W)
Annual population growth rate (2010-2015): 2.7
Total fertility rate (2010-2015): 4.62
Adolescent fertility rate (2010-2015): 98.1/1000
Sex ratio (women per 100 men) (2012): 100
Maternal Mortality rate (2010): 360 (per 100,000l.b.)
CI [230-590]
Infant mortality rate (2010-2015): Total 58 /1000;
Under 5 mortality rate: 89/1000
Contraceptive Prevalence rate 15-49 (2008-2009): any
method: 46% modern methods: 39%
Proportion of births attended by a skilled health
professional: 43.8 (2009)
Source: (UN Stats)
Unmet Need: 25.6% (UNDESA)

Background

Ethiopia faces monumental challenges in the area of SRHR. The TFR remains high at roughly 5 children per woman, while the unmet need for family planning services is at more than 26%, and contraceptive usage remains under 50%, even including traditional methods¹²⁷. The adolescent pregnancy rate remains staggeringly high at 98.1/1000 girls aged 15-19, surpassing even India's rates. Moreover, political turmoil and ethnic-based violence in the past few years has meant that Kenya is now host to over 300,000 refugees, and nearly 1 million internally displaced people, all with urgent (sexual and reproductive) health needs¹²⁸. On a more positive note, FGM/C (female genital mutilation/cutting), outlawed as of 2001, has seen a

decrease,¹²⁹ and a programme to enhance the capacity of midwives and promote the uptake of assisted deliveries was launched on a small scale across four districts in 2008¹³⁰.

Current Scope of SRH Policy Agenda

Section 43(1) of the Kenyan Constitutions states that: 'every person has the right to the highest attainable standard of health, including reproductive health care'¹³¹. Following the ICPD in 1994, UNFPA supported the development of Kenya's first National Reproductive Health Strategy (NHRS 1997-2010) in 1997, and the health component of the National Youth Policy later on. The Strategy calls for the improvement of facility capacity to manage pregnancy-related complications (and thereby reduce maternal mortality), as well as unsafe abortion, newborn care, and the development of a functioning referral system. The strategy was later revised in 2009 with the adoption of the NHRS 2009-2015, to address issues not covered by the first Plan, and to provide better guidance for the National Reproductive Health Policy, launched in 2007¹³².

The first National Reproductive Health Strategy (NHRS) 1997-2010 recognised the need for a multi-sectoral approach in order to implement the full range of RH components, spearheaded by the health sector. The Strategy became a point of reference for RH stakeholders in Kenya, and was a key to the development of the mandate of the Division of Reproductive Health (DRH) of the Ministry of Public Health and Sanitation.¹³³ The Policy (and all associated SRH programmes) is

127. UNFPA Country Profiles 2010 p. 60

128. UNFPA 2010 p. 60

129. UNFPA 2010 p. 60

130. Ibid., p. 60

131. EuroNGOs Policy Brief n. 2 2012

132. Sidze et al 2013 p. 142

133. NRHS 2009-2015 (2009) p. 4

currently overseen by the National Council for Population and Development (NCPD- a semi-autonomous agency within the Ministry of Planning) and the Ministry of Health's Division of Reproductive Health (DRH)¹³⁴

National Reproductive Health Policy (2007)

In 2007, the Ministry of Health formally approved the first National Reproductive Health Policy (NRHP). The document, centred around the provision and protection of the rights of individuals over their health, and enhancing the reproductive health status of all Kenyans, provides a framework for the provision of equitable, efficient, and effective delivery of quality SRH services, as well as the standardization, increased coordination, and careful monitoring and evaluation of SRH programmes, curated by both governmental and non-governmental stakeholders.¹³⁵ Like many of the other strategies discussed in this UNFPA report, Kenya's NHRP emphasizes the prioritization of reaching the most vulnerable and underserved populations where SRH is concerned. In particular, the policy looks at issues including RH commodities security, prevention of mother-to-child transmission of HIV/AIDS, EmOC, Adolescent Reproductive Health (also addressed in several separate documents, including the National Reproductive Health Strategy 2009-2015, the National Adolescent Development Strategy (2003), the Adolescent Reproductive Health and Development Policy (2003), and the Adolescent Reproductive Health and Development Policy Plan of Action 2005-2015), as well as gender-based violence, RH needs of people with Disabilities (also covered by the People with Disabilities Act

of 2003), the reproductive health of Elderly Persons, infertility and assisted reproduction, and SRH/HIV service integration.¹³⁶ The Policy framework also focuses on increasing skilled birth attendance through strengthening midwives' capacity at the community level.

National Reproductive Health Strategy 2009-2015 (2009)

A revision of the National Reproductive Health Strategy 1997-2010, the updated NRHS for the 2009-2015 was the result of a collaboration between the Ministry of Public Health and Sanitation and the Ministry of Medical Services, in order to take into account both vast changes in Kenya's SRH landscape over the past decade, but also to align it more fully with the objectives of the National Reproductive Health Policy framework. The new strategy aims to further focus on creating inter-linkages between SRH and all other sectors of development, and defines the crucial roles of the Ministry of Public Health and Sanitation, Role of Ministry of Medical Services

Division of Reproductive Health, The Provincial and District Health Management Teams, Roles of FBOs, NGOs, CBOs and Private sector, Role of Development Partners, Role of Communities, Households and Individuals, Training Institutions, Research Institutions, Mass Media, and other Stakeholders.¹³⁷ Other stakeholders include development partners, nongovernmental and faith-based organizations, and the private health sector. As with all the other SRH policy-related documents drafted by Kenya, the stated basis of this document is the respect for human

134. RN Oronje. Reproductive Health Matters 2013;21(42):153

135. USAID. Stories from the Field: Kenya Adopts First National Reproductive Health Policy(2007) p. 1

136. USAID. Stories from the Field: Kenya Adopts First National Reproductive Health Policy(2007) p. 2

137. NRHS 2009-2015

rights and freedoms regardless of religion, culture and socio-economic status, in this case particularly with respect to reproductive and sexual health rights.

With regard to SRH system and programme management, the updated NRHS (2009-2015) takes its cues from the National Health Sector Strategic Plan 2008-2010 (NHSSP II), as well as the strategic plans of the Ministry of Public Health and Sanitation and Ministry of Medical Services.¹³⁸ The NRHS includes several sub-strategies for: managing financing mechanisms for SRH services; human resource investment and training; strengthening monitoring and evaluation systems for SRH programmes and usage of resulting data for priority setting (in fact, a list of crucial progress indicators are defined in the NRHS itself); research data collection, management and usage; service quality improvement and monitoring; and improving cross-sectoral, international, and public-private collaboration¹³⁹. The strategy additionally calls for the development of an effective communications strategy to ensure awareness of rights and protections under new policy and standards among communities and healthworkers, strengthening of maternal death review by development of guidelines, increased access to obstetric fistula services, and increased access to skilled attendance at delivery through the community midwifery programme¹⁴⁰.

Other relevant policies and bodies

The National Adolescent Reproductive Health Development Policy (2003)

Developed jointly by the Division of Reproductive Health (DRH) of the Ministry of Public Health and Sanitation, Centre for the Study of Adolescence (CSA), and the National

Council for Population and Development, the Adolescent Reproductive Health and Development Policy (2003) highlights priority areas to meet the needs of Kenya's adolescent population, not the least of which include: reproductive health information and services, HIV/AIDS and STIs, Safe motherhood, Reproductive rights, unsafe abortion harmful practices and violence against (young) women (early marriage, FGM), Drug and substance abuse, and gender-based discrimination.

The Adolescent Reproductive Health and Development Policy Plan of Action 2005-2015

The Reproductive Health and Development Policy Plan of Action 2005-2015 is a companion to the above-described Policy framework, focusing on strategies for advocacy, health awareness and influencing behaviour change among young people, as well as improved access to youth-friendly services.

Other Key SRH Policies and Guidelines:

- Maternal and Newborn Health (MNH) Road Map 2010–2015.
- Kenya National AIDS Strategic Plan III
- National Reproductive Health and HIV and AIDS Integration Strategy (2009)
- Kenya Essential Package for Health (KEPH)
- Norms and Standards for Health Service Delivery (2006)
- Family Planning Guidelines for Service Providers (2005) (revised 2009)
- Contraceptive Policy and Strategy 2002-2006
- Contraceptive Commodities Procurement

138.NRHS 2009-2015 p. 8

139.NRHS 2009-2015

140.p. 58 NRHS 2009-2015

Plan 2003-2006

- Contraceptive Commodities Security Strategy 2007-2012

- Guidelines for the provision of Youth-Friendly Services.

- Child Survival and Development Strategy 2008-2015

- School Health Policy and Guidelines;

- People With Disabilities ACT of 2003

- Guidelines for prevention and management of reproductive organ cancers

- Address needs of vulnerable populations, particularly those displaced and affected by the recent turmoil

- Increase proportion of health facilities providing integrated reproductive health services.

Highlights of Case Study

- Large body of frequently updated policies developed in close coordination with each other in order to ensure a multi-angled approach

- Clear priority-setting approach

- National RH Policy (2007) works in tandem with the 2003 People with Disabilities Act to prevent negative SRH outcomes for people with disabilities (who tend to be more at risk of negative SRH outcomes), as well as addressing the need to reach out to other overlooked populations i.e. the Elderly

Current National Priorities

- Reduce Maternal and Child mortality rates via skilled birth attendance, EmOC and improved referral systems, as well as increase uptake of contraception to avoid unsafe abortion from unwanted pregnancies (in particular: double the rate of contraceptive use among young people)

ETHIOPIA

Indicators

Population Size (in thousands) (2012): 86 539
p.c. GDP (2011) : 357
% Urban population (2012): 17.2
% Population under 15 (2012): 40
% Population over 60+ (2012): 5 (M), 6 (F)
Annual population growth rate (2010-2015): 2.1
Total fertility rate (2010-2015): 3.85
Adolescent fertility rate (2010-2015): 48.3/1000
Sex ratio (women per 100 men) (2012): 101
Maternal Mortality rate (2010): est. 350 (per 100,000.
b.) CI 95 [210-630]
Infant mortality rate (2010-2015): Total 63/1000;
Under 5 mortality rate: 96/1000
Contraceptive Prevalence rate 15-49 (2005): any
method: 15% modern methods: 14%
Proportion of births attended by a skilled health
professional: 5.6 (2000), 5.7 (2005), 10 (2011)
Source: (UN Stats)
Unmet Need: 26.3% in 2011 (UNDESA)

Background

Ethiopia is among the poorest, least developed countries in the Sub-Saharan African region. Around 40% of its population is under 15, and over 80% of the total population lives in rural areas¹⁴¹, making the challenge of providing access to education and (SR) health services and commodities an issue of top concern. Moreover, contraceptive prevalence (all methods) remains consistently low, and although fertility levels have seen pronounced decreases in the last five years, it remains high, coupled with an unmet need for contraception set at 26%¹⁴², setting it among the highest levels of unmet need in the region.¹⁴³

As early as 1997, Ethiopia had already identified SRH problems as key barriers to its development and achieving good health among its population. To this effect, it

conducted a national RH Needs Assessment to identify priorities guide the implementation of a National RH paradigm. The paradigm was drafted to create a consensus on the scope of RH services, as well as develop relevant strategies and act as a frame of reference to implement them. In response to the persisting urgent need to address these problems, the National RH Task Force, chaired by the MOH, formulated and endorsed its latest incarnation of the Reproductive Health Strategy for 2006-2015. Its formulation was also guided by a national Coordinating Committee established specifically for that purpose.

Current Scope of SRH Policy Agenda

The 2006-2015 National Reproductive Health strategy first provides a current overview of (reproductive health) priority areas where Ethiopia is concerned, including status of women and health system capacity building. The plan is further divided into two sections: namely, specific strategies to target the key reproductive health outcomes highlighted in the overview, including women's status, reproductive cancers, HIV/AIDS, MCH, fertility and FP, and the RH of young people.

Ethiopia's Reproductive Health Strategy (2006–2015) is organised around six priority areas for SRH:

- social and cultural determinants of women's reproductive health
- fertility and family planning
- maternal and newborn health
- HIV/AIDS
- Reproductive health of young people
- Reproductive organ cancers.

141.UNFPA and Population Reference Bureau. Country Profiles for Population and Reproductive Health: Policy Developments and Indicators for 2009-2010(2010). P. 49
142.UNDESA 2011

143.UNFPA and Population Reference Bureau. (2010). P. 49

Moreover, the Strategy devotes a substantial section to strengthening supporting systems in the Health Sector in order to ensure progress with SRH. Primarily, they outline a plan to respond to diverse needs of the population, capitalizing on the demands of individuals across gender, geographical, social, and economic strata. The other sections include detailed plans to operationalise: human resource development and capacity building (for SRH) at community, system, and policy levels; Strengthen legal frameworks that protect and advance RH rights; Health Management Information Systems (HMIS); and a Monitoring and Evaluation Framework, as well as a call for research-based policy and programme design.

The needs of young people in particular are singled out as a matter of top priority, as they are both a critically neglected portion of the population, and their needs are cut across all aspects of reproductive health. The Strategy highlights the need to create a separate comprehensive Youth Strategy in order to: “[Address] the immediate and long-term RH needs of young people; and strengthening multicultural partnerships to respond to young women’s heightened vulnerability to sexual violence and non-consensual sex. To achieve this goal developing a comprehensive adolescent’s reproductive health strategy will be the immediate action.”¹⁴⁴

Guided by a national Coordinating Committee, the process of strategy formulation included consultations with stakeholders at national and region levels, extensive literature reviews, the compilation of region-specific technical briefs, and the preparation of the National Reproductive Health Strategy.

Other Relevant Policies and Bodies

National Adolescent and Youth Reproductive Health Strategy for 2006-2015 (2006)

The NRHS called for an institutional framework to address young people’s RH needs and to integrate youth-friendly services into existing programmes. Shortly thereafter, the National Adolescent and Youth Reproductive Health Strategy for 2006-2015 was developed by the Ministry of Health. In it, youth-specific priority objectives in the country are outlined, including tackling early child-bearing, unwanted pregnancy and abortion, STIs/HIV, and uptake of contraception and knowledge of family planning methods. The document also includes strategies to improve access to quality RH and STI/HIV services, community communication and participation, CSE for young people, changing norms and attitudes towards SRH issues among policy-makers and at the policy level, empowering youth and fostering youth participation using cross-cutting multi-sectoral approaches, increasing coordination and collaboration among line ministries, research and training institutions, technical organizations, implementing partners, professional organizations, CBOs, religious organizations, and international donors. Special emphasis is made on gathering more data where there are gaps in knowledge, as well as building up capacity for data management, in order to make informed policy decisions, and further develop programme research and evaluation plans in order to design, implement, and monitor RH programmes (for youth) more effectively. A more detailed monitoring and evaluation plan is described in a separate section, the targets and key indicators of which are designated to be integrated with the other national (health) goals and strategies stated in Ethiopia’s development agenda.

144.NRHS 2006-2015 p. viii

Recent Reforms

- National Reproductive Health Strategy (2006-2015)
- National Adolescent and Youth Reproductive Health Strategy for 2006-2015, developed by the Ministry of Health (2006)

- Increasing couples' approval of family planning by 75% by 2015

Increasing awareness of the links between sexually transmitted infections (STI)/post abortion complications and infertility by 80%;

Partnerships

Ministry of Health, Ministry of Education, Ministry of Rural Development, Ministry of Youth and Sport, Ipas Ethiopia, Pathfinder International, CORHA, Ethiopia Youth Network, FHI, DSW, UNFPA, USAID, UNICEF, WHO, Packard Foundation, Population Council, HCP, YouthNet

Highlights of Case Study

Ethiopia's commitment to address and overcome the immense challenges it faces with regard to SRH today is reflected in its two main, overarching, comprehensive strategies drafted in 2006, putting an emphasis on setting priorities while also taking a sector-wide approach to ensure sustainable progress with programme and policy implementation.

Current National Priorities

- Reaching contraceptive coverage rate of 60% by 2010
- Ensuring awareness of and satisfying demand for contraception up to 80%
- Inclusion of long-term FP service in the job description of mid-level health care providers. (i. e. expanding the Health Extension Program (HEP))

LATIN AMERICA

Regional Overview

Latin America and the Caribbean are characterized by gaping disparity- both across countries and within them. As of 2009, there were 582 million inhabiting the 47 countries included in the region, with relatively lower fertility rates than other developing regions (2.2 in 2009, and still falling)¹⁴⁵, and overall contraceptive usage rates to rival East Asian (i.e. Chinese) averages, but such rates are highly skewed by the most populous states; Brazil and Mexico.¹⁴⁶ On average, however, the region has performed well over the past decade with regard to reaching its MDG target to halve child deaths by 2015 and scaling up prenatal care, although other indicators such as adolescent pregnancy and maternal mortality levels leave much to be desired.¹⁴⁷ In fact, maternal mortality (including unsafe abortion) is one of the leading causes of death for adolescent girls in Latin America.¹⁴⁸ Young people account for roughly 20% of the region's population, and many countries have recognized a need for if not developed youth-specific SRH policies, although their success in implementation has been dependent on capacity. An important characteristic of Latin America's SRH policy processes are the non-state stakeholders that influence policy outcomes. One major player in this regard is the Catholic Church, which has by turns served as a promoter of health, or (more typically) an even stronger opposition force in SRH policy discussion¹⁴⁹. Historically opposed to the Church have been the strong women's (feminist) health

and rights organisations, themselves driving forces of change and advances in SRHR across the region¹⁵⁰. Thanks in no small part to the latter's efforts, countries in the region have also adopted legal and policy frameworks that recognize the need for and aim to protect and promote reproductive rights, freedom from gender-based violence, and gender equality¹⁵¹

Regional Protocols, Strategies, Conventions, Calls to Action, and Commitments

- 1993 Latin American and Caribbean Consensus on Population and Development, Mexico City
- 1994 Programme of Action of the International Conference on Population and Development
- 1994 Latin American and Caribbean Regional Plan of Action on Population and Development (Economic Commission for Latin America and the Caribbean)
- 1995 Convention on the Elimination of All Forms of Discrimination against Women, Beijing
- 2007 The Quito Consensus, adopted at the tenth session of the Regional Conference on Women in Latin America and the Caribbean, held in Quito

145. UNFPA and Population Reference Bureau. Country Profiles for Population and Reproductive Health: Policy Developments and Indicators for 2009-2010(2010). Pp 223-225

146. UNFPA 2010 p. 224

147. UNFPA 2010 p. 224

148. Richardson and Birn 2011 p. 184

149. Richardson and Birn 2011 p. 188

150. Richardson and Birn 2011 p. 190

151. ICPD+20 LACHWN p. 72

- 2010 The Brasilia Consensus, adopted at the eleventh session of the Regional Conference on Women in Latin America and the Caribbean

- 2012 Convention on the Rights of the Child

- 2012 José Charter on the Rights of Older Persons in Latin America and the Caribbean

- 2013 Montevideo Consensus on Population and Development

(Drafted as a result of the First Latin American and Caribbean Conference on Population and Development, Montevideo, 12--15 August 2013, and ECLAC Regional Review of ICPD)

- 2013 Programme of Action of the International Conference on Population and Development in Latin America and the Caribbean beyond 2014

Regional and Sub-regional SRH policymaking/advocacy bodies

- MERCOSUR

- CEPAL, el Comité Especial sobre Población y Desarrollo de la CEPAL

- Centro Latinoamericano y Caribeño de Demografía (CELADE)

División de Población

División de Asuntos de Género (DAG)

División de Desarrollo Social (DDS) de la CEPAL

- Economic Commission for Latin America and Caribbean (ECLAC)

BRAZIL

Indicators:

Population Size (in Thousands) (2012): 198 361

p.c. GDP (2011): 12 594

% Urban population (2012): 84.9

% Population under 15 (2012): 24

% Population over 60+ (2012): 10 (M), 12 (W)

Annual population growth rate (2010-2015): 0.8

Total fertility rate (2010-2015): 1.8 (compare to 1990: 2.8 and 1970: 5 – see UNICEF indicators)

Adolescent fertility rate (2010-2015): 76.0/1000

Sex ratio (women per 100 men) (2012): 103

Maternal Mortality rate (2010): est. 56 (per 100,000l. b.) CI 95 [36-85]

Infant mortality rate (2010-2015): Total 19/1000; Under 5 mortality rate: 24/1000

Contraceptive Prevalence rate 15-49 (2006): any method: 80%, modern methods: 77%

Proportion of births attended by a skilled health professional: 69.5 (1991), 87.6 (1996), 97 (2006)

Source: (UN Stats)

Unmet Need: 6% in 2006 (UNDESA)

Background:

Brazil is currently a middle-income country with a mostly urbanized population. Among the many challenges to development the country faces; i.e. poverty, rural and urban inequalities, sanitation, and urban slum formation- sexual and reproductive health (for adolescents in particular) remains high on the list of development priorities.

The 1990s saw a major shift in Brazil's attitude and approach towards family planning and reproductive health. Like many countries of comparable population size, it had until then been primarily concerned with managing its population size and demographics through family planning programmes. However, their persistent SRH inequalities across economic, social, and geographic strata despite their marked fertility and maternal mortality decline over the past few decades led to a reorientation of priorities and policies where those issues were concerned, in tandem with

many other countries at the time and reflected in the issues critically highlighted by Brazil and other key national participants at the ICPD in 1994.

Current Scope of SRH Policy Agenda

Brazil's current SRH framework is still encapsulated within the Programa de Assistência Integral à Saúde da Mulher (or Comprehensive Programme for Women's Health (PAISM), but services are gradually being integrated into the SUS primary health care package. The PAISM takes a client demand-oriented perspective, taking the stance that 'Family planning is perceived as a matter of individual choice rather than a strategy for population control'.¹⁵² Consequently, Brazilian government strives to cover all issues outlined by the ICPD as essential to a comprehensive SRH agenda and incorporate them within the Universal Health System, which includes built-in M&E framework for health sector services in general. Notable in their commitment to the approach inherent in these principles is the way the Brazilian government has stated it will address the problem of being a middle income country with a declining overall fertility rate (despite a persistently high adolescent pregnancy rate): namely, by making strides towards improving gender equality and creating an environment conducive to planned, desired pregnancies.

Issues currently highlight by the PAISM policy framework:

The Programa de Assistência Integral à Saúde da Mulher (or Comprehensive Programme

for Women's Health (PAISM) takes a life-course approach to women's health, including Maternal and Child health (antenatal, delivery, and post-natal care), Adolescent Health, STI care, Reproductive Cancer Prevention, Menopausal care and Contraception (family planning methods).

Other Relevant Policies and Bodies:

The Constitution that was adopted in 1988 established the principle of Gender Equality as a cross-cutting priority [S. Correa et al] and freedom of choice and access to family planning. It 'defined health as a right and set forth the Integrated Health System (Sistema Único de Saúde, or SUS) as a universal, integrated policy with built-in public accountability through health councils at national, state, and local levels.'¹⁵³ Much later, in 2003, the Special Secretariat on Women's Policies was formed specifically to address gaps in the more holistic and cross-cutting vision of SRH adopted by the government shortly before the ICPD¹⁵⁴

With regards to a youth strategy, a National Youth Policy document was being drafted as a result of the first National Youth Conference to discuss challenges and priorities for addressing the health needs of Brazilian adolescents.¹⁵⁵

Scope of the National Health System (Sistema Único de Saúde or SUS)

The Brazilian national health system (Sistema Único de Saúde or SUS) is based around the concepts of universal access, comprehensiveness, decentralization, hierarchization, and community participation.

152. Rios-Neto, Eduardo. 2010. "Statement Made by Dr. Eduardo Rios-Neto, Delegation of Brazil to the Forty-third Session of the Commission on Population and Development Under Agenda Item 6: The Contribution of Population and Development Issues to the Theme of the Annual Ministerial Rev." In Commission on Population and Development: 43rd Session, 6. New York.

153. Corrêa, S. et al. 2005. "The Population and Reproductive Health Programme in Brazil 1990-2002: Lessons Learned."

154. Oliveira, Maria Coleta De. 1997. Population Policies and Health : the Brazilian Experience in Reproductive Health. Guadelajara. p. 6

155. UNFPA and Population Reference Bureau. Country Profiles for Population and Reproductive Health: Policy Developments and Indicators for 2009-2010(2010). P. 236

It includes public health in general and health care for individuals. About 70% of Brazil's population gets health care from the SUS, with the remainder opting instead for private sector services and insurance schemes. Within the SUS, the majority of the primary care services are delivered by the public sector, while hospital, diagnostic, and therapeutic support are provided by both the public and private sectors.

National Health Council and subnational health councils provide mechanisms for citizen participation and oversight. They address core issues of priority setting and accountability and can challenge health system managers or policies, rather than merely participating in implementation, and promote engagement from civil society, service providers, and public officials.

Recent Reforms

- Policy of Comprehensive Attention to Assisted Human Reproduction (2006) to address Infertility
- National Policy for Family Planning (2006) to provide free birth control commodities to both men and women of reproductive age
- Policy to promote natural childbirth and cut down on unnecessary caesareans
- Same policy to define deadlines for municipal health care workers to investigate maternal health (to increase efficiency and efficacy)

Highlights

- Primary SRH policy document encompasses a wide range of issues both pertaining to the scope and management of SRH services, particularly emphasizing a life-course approach to service provision and an individual choice model.

- Typically over-emphasizes women's issues due to historic lower status of women in the country, but this is now being addressed with more generally targeted policies.

- Other improvements could include developing specific SRH programme M&E guidelines to better keep track of SRH policy impacts, as well as measures to strengthen the health system for SRH provision, and longer-term goals should include the complete integration of the policies outlined by the PAISM into the general health care system.

Current national priorities

- Lowering the maternal and infant mortality rate, esp. maternal to 35/100,000l.b.
- Extend the promotion of universal SRHR coverage(as essential primary care)to all provinces
- Address RH cancers and Adolescent fertility rates
- Reduction of domestic/GB violence and feminization of HIV/STIs

MEXICO

Indicators

Population Size (in thousands) (2012): 116 147
p.c. GDP (2011): 10 063
% Urban population (2012): 78.4
% Population under 15 (2012): 28
% Population over 60+ (2012): 9 (M), 10 (W)
Annual population growth rate (2010-2015): 1.1
Total fertility rate (2010-2015): 2.23
Adolescent fertility rate (2010-2015): 65.5/1000
Sex ratio (women per 100 men) (2012): 103
Maternal Mortality rate (2010): 50 (per 100,000l.b.) CI 95 [44-56]
Infant mortality rate (2010-2015): Total 14 /1000;
Under 5 mortality rate: 17/1000
Contraceptive Prevalence rate 15-49 (2006): any method: 71% modern methods: 67%
Proportion of births attended by a skilled health professional: 85.7 (1997), 93.4 (2006), 96 (2012)
Source: (UN Stats)
Unmet Need: 9.8% in 2009 (UNDESA)

Background

Mexico is well on its way to surpassing the demographic dividend; a populous Latin American country with a relatively high contraceptive prevalence rate, its TFR is currently at 2.2 (just above replacement level) and expected to keep falling over time. Although performing well in other aspects of SRH, Mexico's MMR is still lagging behind—particularly among indigenous communities, itself a reflection of persisting inequalities across social and economic strata. Mexico is also experiencing heavy migration flows (both in and out of the country), which presents health issues and access issues particular to this group (including the facilitated spread of HIV/AIDS), along with the added risk of violence and sexual exploitation run by

women and child migrants.¹⁵⁶ Nonetheless, much progress has been made with regard to gender equality and women's rights. In fact, in 2007, Mexico City's legislative assembly voted to legalise abortions up to 12 weeks of gestation¹⁵⁷, although more pernicious forms of discrimination exist, as does gender based violence.

Like Brazil, the 1970s brought with them a shift from thinking about family planning as a tool for controlling population pressure to a tool for citizens to exercise their right to control over their fertility, as well as fulfill their other SRH needs. In 1974, the Constitution was modified to include the right of all Mexicans to freely (but responsibly) decide on the number and spacing of their children.¹⁵⁸ From then on, family planning information and services were provided by the public health sector. Mexico later went on to become a leader during the 1994 ICPD in Cairo, after which its policies became more focused on improving the quality of services, promoting gender equality, reducing social differences, and adopting an approach to SRH more in line with individual rights.¹⁵⁹ During the past decade, special attention has been given to increasing services for young people, particularly in response to high levels of early sexual debut.¹⁶⁰

The first National Family Planning Programme was set up in 1977 (for the 1977-1982 period), although it was not until the updated version of 1995-2000 that SRH was recognised as a basic and important aspect that affected all healthcare programmes. Subsequently, the programme became known as the National Family Planning and Reproductive Health Programme.¹⁶¹ Meanwhile, the National

156. UNFPA and Population Reference Bureau. Country Profiles for Population and Reproductive Health: Policy Developments and Indicators for 2009-2010(2010). P. 268

157. UNFPA and Population Reference Bureau (2010). P. 268

158. Guttmacher adolescents p. 19

159. Guttmacher adolescents p. 20

160. Guttmacher p. 2

161. Guttmacher p. 2

Development Plan (2007-2012) was developed in tandem in order to reduce healthcare access inequalities, particularly among marginalised, disadvantaged, and otherwise marginalised groups.¹⁶²

Current Scope

Mexico was one of the first countries in the world to adopt a holistic approach to SRH.¹⁶³ As of 2003, the National Centre for Gender Equality and Reproductive Health (or CNEGySR), a department of the Ministry of Public Health Promotion and Prevention has been primarily responsible for generating all policies for national RH, family planning, and maternal and child health programmes.¹⁶⁴ This agency, found on the principle of promoting women's rights and the elimination of domestic violence, has duly made efforts to mainstream a gender equality perspective within SRH policy discussion.¹⁶⁵

National Health Programme (2001-2006)

Launched in 2011, the CNEGySR's action plan for reproductive health is based on three overarching principles: on the patients' rights to information, respect for human dignity and thus SRHR, and the right of equal access to high-quality services.¹⁶⁶ The Plan outlines seven components that in themselves are strategic plans for SRH interventions. The Plan notably excludes maternal and infant health in its agenda, as these programmes have already been integrated in the 'Equal Start in Life' programme, and likewise excludes measures for addressing Reproductive cancers, which

have been specifically addressed through the Programmes of Action for the Prevention and Control of Cervical-uterine and Breast Cancers.¹⁶⁷ Of the other components of SRH highlighted throughout the report, family planning is a major focus of the National Comprehensive Health Programme, and is considered central to the successful and sustainable development of the country (both on a rights-based and demographic level). According to the Plan, family planning services form part of the national strategy for the reduction of ill-health among socially and economically disadvantaged groups, as well as serving to link the country's gender equality promotion and social and economic development agendas.¹⁶⁸ A major success of the objectives of the Plan of Action has also been the strengthening of linkages and increased coordination across different levels of government: namely, federal, provincial, municipal, and regional.¹⁶⁹

Mexico's Comprehensive Health Plan identifies the following priority areas: SRH for men, SRH for adolescents, SRH for people with disabilities and indigenous populations. Contraceptives: access to information and family planning services, address unmet need for family planning, involving men and boys in family planning. Other areas covered include: Infertility, menopause, unplanned pregnancies, unsafe abortions, and STIs among adolescents. Stated goals include improving SRH service quality overall, monitor and evaluate usage/quality to inform policy, and establish linkages across the health sector as a whole.

162. Programme of Action 2001 p. 7

163. Guttmacher p. 21

164. Guttmacher Salud maternoinfantil p. 21

165. Guttmacher p. 21

166. Programa de Accion 2001 p. 30

167. Programa de Accion 2001 p. 13

168. Programa de Accion p. 13

169. Programa de Accion p. 13

Key strategies include: identifying municipalities with the poorest SRH performance indicators and target these first; building up technical capacity and human resources at the service provision level; guaranteeing access to information, education, and health promotion to all segments of the population; designing a comprehensive, periodic, and systematic monitoring and evaluation framework; and promoting youth-friendly SRH services.

The document then breaks down these strategies step-by-step, with a special emphasis on conducting preliminary research and strengthening coordination between key stakeholders and health service providers (both private and public).

The document then outlines a specific, detailed plan for monitoring and evaluation, beginning by stipulating that all indicators to be used forthwith should be: results-based, able to be measured on an annual basis, allow for international comparisons, be verifiable by third parties, be socially relevant, ensure a broad coverage of what is being measured, and be easily understandable to the public.¹⁷⁰

The document then lists 21 main indicators by which to evaluate progress, and highlights the future direction, including setting priorities and objectives, to improve access to information and services of satisfactory quality equally across the country's diverse regions. Moreover, the document acknowledges and calls upon the engagement of all relevant public and private sector institutions as well as collaboration with CSOs.¹⁷¹

Other Relevant Policies and Bodies

Related Bodies of Governance:

- National System for Family Development (specializes in implementing interventions for young people, particularly addressing adolescent pregnancy and domestic violence)

Relevant Policies and Laws:

- National Health Programme (2001-2006)

- National Reproductive Health Strategy (2001-2006)

- National Protocol on Family Planning Services (NOM-005-SSA 2-1994)

- National Development Plan (2007-2012) (also included some attention to Reproductive Health, particularly for marginalised populations)¹⁷²

- Programme of Action for 2007-2012 'Equal Start to Life' under the Ministry of Health (specific attention to EmOC and developing protocols to identify high-risk pregnancy)¹⁷³

Highlights of Case Study

- Strong emphasis on setting targets and avoiding overlap between programmes to ensure efficiency, but also promoting cross-sectoral collaboration

- As in many Latin American countries, solid historical relationship with feminist CSOs has led to early gender mainstreaming in SRH policy development

170. Programa de acción p. 41

171. Programa de acción p. 9

172. Guttmacher 2010 p. 2

173. Guttmacher 2010 p. 2

- National Health Programme identifies the need to reach vulnerable populations, but with a particular emphasis on people with disabilities

Current National Priorities

- Address standing disparities in health between urban/rural populations, as well as targeted approaches for marginalised groups, e.g. Indigenous populations (particularly for maternal mortality and morbidity)

- Adolescent pregnancy and early age of sexual debut

ARGENTINA

Indicators

Population Size (in thousands) (2012): 41 119
p.c. GDP (2011): 10 994
% Urban population (2012): 92.7
% Population under 15 (2012): 24
% Population over 60+ (2012): 13 (M), 17 (W)
Annual population growth rate (2010-2015): 0.9
Total fertility rate (2010-2015): 2.17
Adolescent fertility rate (2010-2015): 54.2/1000
Sex ratio (women per 100 men) (2012): 104
Maternal Mortality rate (2010): 77 (per 100,000l.b.) CI [67-87]
Infant mortality rate (2010-2015): Total 12 /1000;
Under 5 mortality rate: 14/1000
Contraceptive Prevalence rate 15-49 (2001): any method: 65 modern methods: 64
Proportion of births attended by a skilled health professional (2011): 97.1
Source: (UN Stats)

Background

Argentina, somewhat like Brazil, is facing both the pressures of an ageing population (with TFR currently set at replacement level) as well as persistently high adolescent fertility rates and morbidity caused by gender based violence.¹⁷⁴ The maternal mortality rate also remains high due to unsafe abortion, which is still against the law in Argentina, although the former Minister of Health identified its decriminalisation as a key strategy to reduce maternal deaths.¹⁷⁵

During the period of military dictatorship up until 1983, conservative policies on family planning and SRH prevailed in the country. After its abdication in 1983, laws restricting access to and use of contraception and family planning methods were annulled, and an SRH model based on individual choice and responsibility was adopted.¹⁷⁶ Currently, the main policy body governing SRH service

174. UNFPA Country profiles 2009-2010p. 226

175. UNFPA Country profiles 2009-2010p. 226

176. PROGRAMA NACIONAL DE EDUCACIÓN SEXUAL INTEGRAL LEY NACIONAL Nº 26.150 LINEAMIENTOS CURRICULARES PARA LA EDUCACIÓN SEXUAL INTEGRAL 2008, p. 25

provision and management is Law 25.673 on Responsible Sexual Health and Procreation. In its incipient stages, from 2003-2006, the resulting National Programme for Sexual Health and Responsible Procreation (known as the PNSSyPR), fell under the authority of the National Maternal and Child Strategy. Post-2006, the PNSSyPR became autonomously administrated under the Department of Sanitary Policies.¹⁷⁷ The PNSSyPR stresses the importance of protecting all sexual and reproductive rights of the population, and strove to embed this mindset at the service delivery level among clinical staff and health providers. As of 2010, the provision of contraceptives for the entire population was guaranteed. Moreover, an evaluation system was set up to monitor the progress of SRH programmes.¹⁷⁸

Current Scope of SRH Policy Agenda

National Programme for Sexual Health and Responsible Procreation (Programa Nacional de Salud Sexual y Procreación Responsable, or PNSSyPR)

Enacted as of 2002, the main objectives of the PNSSyPR include: to aid the population in reaching the highest level of sexual and reproductive health based on their own decisions, free of coercion or discrimination; to decrease maternal and child morbidity and mortality; to prevent unwanted pregnancies; to promote adolescent sexual health; and to contribute to the early detection and treatment of STIs and HIV, as well as NCDs related to the reproductive system.¹⁷⁹ Further aims are to guarantee equitable access to

complete information on SRH as well as goods and services, to strengthen provincial SRH programmes and build capacity of health workers at the community-level, and to promote the rights of women to freely make decisions about their SRH and fertility.¹⁸⁰ Contraceptives currently distributed via the Programme include: the combined oral pill, injectables, emergency contraception, and condoms. Contraceptives may be acquired without the consent of a partner or a parent as of the age of 14¹⁸¹. Recently, the Ministry of Health also released a set of guidelines on ensuring barrier-free contraceptive provision.¹⁸²

The Strategy takes a comprehensive, patient-oriented, life-course approach to SRHR service provision (especially after the 2013-2014 update). Of particular note is the inclusion of a call for a national programme for Comprehensive Sexuality Education, to be integrated into the national school curriculum, as well as the specific emphasis on engaging the community level to increase demand and uptake of SRH services, the provision of a supportive legal framework for SRHR policy, robust information management, monitoring and evaluation protocols, and notably, the need to include pleasure and sexual orientation along with gender mainstreaming when developing SRHR programmes.¹⁸³

National Programme for Sexual Health and Responsible Procreation (2013-2014)

As the above paragraph explains, universal, free access to SRH services, quality of care, and comprehensive service provision (with

177. Políticas de salud sexual y salud reproductiva. Avances y desafíos Informe de Balance 2003-2011 Programa Nacional de Salud Sexual y Procreación Responsable p. 34

178. Políticas de salud sexual y salud reproductiva. 2003 p. 34

179. Ministerio de salud Argentina. Derechos Sexuales y Derechos Reproductivos : Leyes que reconocen tus derechos 2013. P. 8

180. Ministerio de salud Argentina. 2013. P. 8

181. Boletín no. 1 p. 2

182. MoH Boletín no. 1 p. 2

183. Programa Nacional de Salud Sexual y Procreación Responsable, 2013-2014.

the except for abortion services) are the central tenets of the national programme. The most recent incarnation of this programme now includes SRH issues of women during their reproductive and post-reproductive years, up until the age of 65. ¹⁸⁴The PNSSyPR calls for the close coordination of provincial governments as well as strengthening governance mechanisms and service provision at the lowest levels of primary care ¹⁸⁵ to ensure comprehensive SRH coverage for the entire population, and especially with regard to adolescents and young people, currently a main SRH policy priority in Argentina. ¹⁸⁶

Argentina's National Consortium on Reproductive and Sexual Health is responsible for the monitoring of the implementation of law 25.673 (National Programme for Sexual Health and Responsible Procreation). To do this, it has developed several instruments to evaluate quality of services via measuring quantitative and qualitative indicators on both the PNSSyPR's performance as well as performance of provincial governments in implementing the programme. It has also set up community-based evaluation tools to ensure greater accountability for tax-payers. ¹⁸⁷

Other relevant policies and bodies

Argentina boasts a large body of legislation and policy in support of SRHR goals. Paramount among these is Law 25.673, which was responsible for the development of the PNSSyPR as well as the Law on the Equality of Marriage (same-sex) and most recently, for Law 26.743 on Gender Identity and freedom of discrimination for all people regardless of their sexual or chosen gender orientation. ¹⁸⁸

Other supportive laws, policies, and statutes include ¹⁸⁹:

- The National Programme for Comprehensive Sex Education (Law 26.150) (2008)
- Law on Surgical Contraception (Law 26.130), including surgical severance of the fallopian tubes as well as vasectomies. (2006)
- National Guidelines for Special Attention to Adolescents in high-quality Youth-Friendly Spaces (2012)
- Law on the Prevention, Sanctioning, and Eradication of Violence against Women (Law 26.485) (2009)
- Law on the Rights of the Patient with relation to Healthcare Professionals and Healthcare Facilities (Law 26.529) (2009)
- Law Establishing the Right of Freedom of Gender Identity of all Persons (Law 26.743) (2012)

Highlights of Case Study

- A remarkable development for the region, Argentina has established a law on the freedom of gender association (and sexual orientation) of all of its citizens, which guarantees not only the improved uptake of
- services among otherwise marginalised communities, but protects them from violence and discrimination.
- Comprehensive, set guidelines for CSE at the national level, regularly updated

184. Informe Prensa Argentina 2014. p. 2

185. Ministerio de Salud. "Salud Sexual: Acceso universal garantizado" Boletín Bimensual de Salud Sexual y Reproductiva no.1 (2010), p. 2

186. Ministerio de Salud. "Salud Sexual: Acceso universal garantizado" Boletín Bimensual de Salud Sexual y Reproductiva no.1 (2010), p. 1

187. Boletín no. 1 2010 p. 7

188. Informe Prensa Argentina 2014 p. 1

189. Ministerio de salud Argentina. Derechos Sexuales y Derechos Reproductivos : Leyes que reconocen tus derechos 2013. P. 22

- High level of inter-institutional cooperation (e.g. MoH and MoE must collaborate in order to maintain the standards set by Law 26.150 on CSE)

Current National SRH Priorities

- Improvement of Maternal and Child Health indicators
- Eliminate unwanted pregnancy and preventable cervical cancer
- Strengthen SRH programmes at both the National and Provincial level
- Update and maintain a comprehensive legal framework to support the efforts of SRH programmes

ASIA PACIFIC

Regional Overview

The Asia-Pacific region covers countries in varying states of population makeup and socio-economic development. While it does not rank the poorest in SRH performance (although the average for regional indicators is not indicative of the massive differences between OECD countries like Japan vs. low income countries like Cambodia), Asia Pacific is also the most populated region in the world (population estimated at 3.7 billion people in 2009).¹⁹⁰ China alone is home to 1.4 billion citizens, while India accounts for 1.2 billion—a figure expected to rise enormously in the coming decades¹⁹¹. This means that at least in absolute terms, it is necessarily a region with a huge volume of unmet SRH needs. Case in point: the combined number of cases of curable STIs in the Asia Pacific region accounts for almost half of the global burden.¹⁹² Notable cases of successful HIV prevention interventions are Cambodia and Thailand, whose state-driven condom-use campaigns helped drive down HIV/AIDS incidence.¹⁹³ As well as being the most populous region overall, Asia-Pacific also hosts the biggest share of young people (ages 10-25) in the world, estimated to have reached 1.8 billion by 2009.¹⁹⁴ Adolescent SRH needs have thus been recognized in several policy frameworks in the region as a matter of priority¹⁹⁵. Meanwhile, people above the age of 60 made up 10% or

the population (expected to increase to 17% by 2025).

Aside from China, where contraceptive use has already reached 90%, more than 50% of the women in the region are using any method. Fertility levels also vary wildly across the region; ranging from 1.7 in Iran to 6.4 in Afghanistan (although, except China, the average TFR for the region is 2.6).¹⁹⁶ Several countries in the region have displayed progress in the areas of maternal and child health; for example, Cambodia's marked increase in percentage of births attended by trained health staff (44% in 2005 to 70% in 2010), which arguable led to a reduction in the national MMR from 430 out of 100,000 live births to 250 in their respective years.¹⁹⁷ Abortion services are only legal in Vietnam, Cambodia, China and Lao PDR.

Gender inequality (and its negative effects on SRH) poses one of the most serious threats to health in the Asia Pacific Region. Long-standing traditions of discrimination against females and son-preference allow for the persistence of prenatal sex selection, forced marriage, gender-based violence, and social and economic exclusion of women. Gender inequality, as mentioned above, leads to gender imbalance— in 2009, for every 100 female births in China, there were 120 males, a condition paralleled in some states in India

190. UNFPA and Population Reference Bureau. Country Profiles for Population and Reproductive Health: Policy Developments and Indicators for 2009-2010(2010). P. 107-110

191. UNFPA (2010). P. 108

192. UNFPA (2010) 0. 107

193. WHO Asia Pacific Operational Framework for linking HIV/STI Services with Reproductive, Adolescent, Maternal, Newborn, and Child Health Services 2008 p. 3

194. UNFPA (2010) p. 107

195. AP thematic papers 2012 p. 31

196. UNFPA (2010). P. 107

197. ESCAP review of challenges to implementing ICPD PoA in AP region 2013 p. 6

where fertility has fallen and income is high enough to permit screening for foetal sex.¹⁹⁸ In response, countries in the region have begun to develop and implement reforms to address gender inequality and the elimination of violence against women.¹⁹⁹

Regional Protocols, Strategies, Conventions, Calls to Action, and Commitments

- 1979 International Convention on Elimination of All forms of Discrimination against Women (CEDAW).
- 1992 Bali Declaration on Population and Sustainable Development
- 1993 United Nations World Conference on Human Rights.
- 1994 UN International Conference on Population and Development. (ICPD, Cairo) (and All follow-up Plans of Action, i.e. ICPD +5, +10, +15, Follow-up post-2014)
- 2011 Strategic Actions agreed at the Regional Consultation with Parliamentarians and Policy Makers on Family Planning and Reproductive Health in South Asia – Addressing the Challenges
- 2012 Kuala Lumpur Plan of Action To accelerate the achievement of SRHR in Asia-Pacific (set up by CSOs in ASEAN Region)²⁰⁰

INDIA

Indicators

Population Size (in thousands) (2012): 1 258 351
 p.c. GDP (2011): 1 528
 % Urban population (2012): 31.6
 % Population under 15 (2012): 30
 % Population over 60+ (2012): 7(M), 9 (W)
 Annual population growth rate (2010-2015): 1.3
 Total fertility rate (2010-2015): 2.54
 Adolescent fertility rate (2010-2015): 75.7/1000
 Sex ratio (women per 100 men) (2012): 94
 Maternal Mortality rate (2010): 200 (per 100,000.l.b.)
 CI 95 [140-310]
 Infant mortality rate (2010-2015): 48/1000; Under 5 mortality rate: 65/1000
 Contraceptive Prevalence rate 15-49 (2005/6): any method: 56% modern methods: 49%
 Proportion of births attended by a skilled health professional: 42.5 (2000), 46.6 (2006), 52.3 (2008)
 Source: (UN Stats)
 Unmet Need: 20.5% in 2008 (UNDESA)

Background

India is currently the second-most populous state in the world, and if the growth rate remains unchanged, it may well surpass China in time (projected estimates set at 2050)²⁰¹. Along with China, India holds the somewhat unique position of being both one of the largest and fastest economies in the world (as well as being one of the BRICS countries), and yet still host to enormous disparities in health within the country itself. Maternal mortality remains a challenge (although it has been declining), estimated to be at 200 deaths per 100,000 live births in 2012, a figure that varies widely on a regional level.²⁰² Several districts in India also have a high prevalence of HIV, and given that India's adolescents make up an ever-larger share of their population, rising HIV and STI prevalence among young people

198. Policy Developments and Indicators for 2009-2010(2010). P. 107-110

199. ESCAP 2013 p. 19

200. AP thematic papers p. 143

201. UNFPA and Population Reference Bureau. Country Profiles for Population and Reproductive Health: Policy Developments and Indicators for 2009-2010(2010). P. 128

202. UNFPA 2010 p. 128

is a vital concern. Sex ratio imbalance is also a key issue for both India and China. India's latest legislation on the matter seems to hold much promise, but there is much work to be done if the problem, deeply rooted in gender inequality, is to be solved²⁰³.

India's reproductive health approach has changed over the decades. The Family Welfare Programme was initially a result of India's initial focus on fertility control to stem its rampant population growth. Over the decades, however, it has undergone a number of metamorphoses and changed in direction, priorities, and strategy. However, its primary concern is still demographic changes and targets.²⁰⁴ Meanwhile, India's newest Reproductive, Maternal, Child and Adolescent Health programme is the newest policy framework developed under National Rural Health Mission (NRHM), and it represents a line of thinking much more in tandem with the ICPD agenda for SRHR. The National Rural Health Mission programme has aided India in making significant strides where health is concerned. At its centre, the NRHM's primary objective is to provide equal access to quality health for all Indians, using a life-course approach to health, making strong referral linkages between community and facility-based services, and particularly focusing on extending these services to those socially and economically disadvantaged, as well as those living in rural areas²⁰⁵.

Current Scope

The RMNCH+A document first gives an updated overview of the current SRH situation in India. In doing so, it sets the policy priorities for the next five years-

namely focusing on addressing persistently high rates of maternal mortality in some provinces, as well as reaching vulnerable and underserved populations, e.g. 'tribal' groups and adolescents. It then sets clear goals and targets²⁰⁶, a strategic plan for RMNCH+A Interventions across the life stages and what services to provide at the community, sub-centre, and clinical levels, health system strengthening measures, programme management guidelines, monitoring, information and evaluation systems, guidelines for encouraging community participation, a behavioural change communication strategy, a plan for priority actions in high-focus districts and sites of vulnerable populations, as well as convergence and mainstreaming of services and fostering partnerships, and notes for technical support for RMNCH+A service delivery.

Of particular note is the MoH's recent addition of an adolescent reproductive and nutritional health strategy to their overall RH health framework as a matter of top priority, considering their relatively high rates of unintended pregnancy and low rates of receiving sex education or relevant information (p. 13). Their adolescent health strategy also recognizes the 'diverse nature of adolescent health needs', adopting a cross-cutting approach to health by addressing mental health, nutrition, gender-based violence, non-communicable diseases and substance abuse as well as SRH through promotion, prevention, diagnosis, treatment, and referral interventions. Also notable is their continued efforts at the policy level to address their sex-ratio imbalance by excising stricter controls to prevent sex-selective abortions under the Pre-Conception & Pre-Natal Diagnostic Test

203. UNFPA and Population Reference Bureau. Country Profiles for Population and Reproductive Health: Policy Developments and Indicators for 2009-2010(2010). P. 128

204. pop council young people 2007 p. 2

205. A strategic approach to reproductive, maternal, newborn, child and adolescent health (RMNCH+A) in India. Ministry of Health and Family Welfare. 2013 p. iii

206. RMNCH+A 2013 p. 10

(PC&PNDT) Prohibition of Sex Selection Act, as well as sensitizing communities, service providers, and other stakeholders on the issue, in order to ensure progress with combating son preference while also protecting women's rights under the objectives of the Medical Termination of Pregnancy (MTP) Act.²⁰⁷

The Health Systems Strengthening for RMNCH+A services plan includes steps to build up the health system's infrastructure to meet the goals outlined earlier in the document, increasing capacity of health providers and improving human resource management and training, setting up a public health cadre for improved and efficient monitoring and evaluation of health programmes, evaluation of training institutions, and clear guidelines on services and drugs covered, subsidized, or made reimbursable with public funds. Indicators for quality of care and the structure and staffing of programme management units are also laid out, as are detailed plans for managing governance by focusing on three core areas: responsiveness, transparency, and accountability issues. The Monitoring, Information and Evaluation systems were developed specifically within the document with RMNCH+A services in mind, but are meant to be in tandem with the policy and programme outlines for the rest of the health sector. Additionally, a national and state 'scorecard' is being introduced as a tool to increase transparency and accountability, and aid in tracking progress of interventions. The proposed strategy for fostering community participation entails working with existing channels for direct citizen engagement to aid in the planning, monitoring and implementation of healthcare services at the community level, all in order to improve service delivery and increase accountability.

Finally, the need to form partnerships and converge with existing related programmes is fully addressed, and the document identifies key programmes and partners with whom collaboration is essential.

In short, the document offers a highly-detailed, integrated approach for rolling out comprehensive and well-monitored demand-controlled SRH services at the municipal, provincial, and state levels.

Other relevant Policies and Bodies:

National Adolescent Health Strategy

The first policy document to recognize the distinct needs of adolescents in India was the National Population Policy drafted in 2000. Its mandate focused on decentralizing planning and implementation of services, streamlining service delivery at the grassroots, empowering women and encouraging male involvement, meeting the unmet need for family planning services, targeting underserved groups, and forging private-public partnerships. More importantly, it acknowledged adolescents as a group in need of SRH services, and paved the way for later SRH strategies that incorporate adolescents' diverse needs, regardless of marital status. It also calls on the health sector to provide 'youth-friendly' services, free of discrimination, including training protocols for healthcare providers²⁰⁸.

Also known as the Rashtriya Kishor Swasthya Karyakram (RKSK), the National Adolescent strategy is the latest attempt of the Government of India to address issues in adolescent health and well-being. Launched by the Ministry of Family Health and Welfare in January of 2014, it targets adolescents from

207. RMNCH+A 2013 p. 18

208. Pop council 2008 p. 5

10-19 years of age, prioritizing the needs of those most vulnerable, including SRH. The strategy has yet to be fully implemented but this latest development represents an important step in improving the lives of India's young people, by updating the methods and approaches with which the Government of India can meet their needs. Earlier strategies for young people included the National Youth Policy (2003), drafted by the Ministry of Youth Affairs and Sports, which addressed the needs of those aged 13-35 (although recognizing those from aged 13-19 as a special-needs group)²⁰⁹. Also of note was the presence of the needs of adolescents and youth in the Five-year Plans (especially the Tenth and Eleventh), with special regard to the National Adolescent Reproductive and Sexual Health Strategy produced during that time; the action plan of the Tenth Plan clearly states adolescents as a priority group with distinct (SRH) needs²¹⁰.

Recent Reforms

- RMNCH+A was added to the Family Health programme and policy body in 2013
- The new Rashtriya Kishor Swasthya Karyakram (RKSK), or National Adolescent Strategy, drafted in 2014, reputed to be the most progressive and comprehensive yet, recognizing the rights of adolescents to access a full range of SRH services.

Highlights of Case Study

- As a BRICS country, India's model for SRH policy is of use to other countries of similar population size and dynamics

- India has transitioned from being solely focused on fertility control to a strong promoter of patient rights, freedom of choice, and universal access to health, however demographic pressures remain an area of concern

- The latest developments in India's SRH policy (including the RMNCH+A) reflect a recognition of a need to coordinate efforts to tackle the interrelated causes of sexual and reproductive ill-health, across the life-course.

Current National Priorities

The 12th Five Year Plan has defined three goals as matters of national priority, primarily concerned with reducing maternal and child mortality:

- Reduction of Infant Mortality Rate (IMR) to 25 per 1,000 live births by 2017
- Reduction in Maternal Mortality Ratio (MMR) to 100 per 100,000 live births by 2017
- Reduction in Total Fertility Rate (TFR) to 2.1 by 2017

They also include improvements in the areas of:

- Adolescent SRH
- Improvement of service delivery, meeting unmet need for FP
- Preventing the spread of HIV/AIDS

209. pop council young people 2007, p. 8

210. Pop council p. 8

THAILAND

Indicators

Population Size (in thousands) (2012): 69 892
p.c. GDP (2011): 5 318
% Urban population (2012): 34.4
% Population under 15 (2012): 20
% Population over 60+ (2012): 13 (M), 15 (W)
Annual population growth rate (2010-2015): 0.5
Total fertility rate (2010-2015): 1.53
Adolescent fertility rate (2010-2015): 37/1000
Sex ratio (women per 100 men) (2012): 104
Maternal Mortality rate (2010): 48 (per 100,000l.b.) CI [33-70]
Infant mortality rate (2010-2015): Total 11 /1000;
Under 5 mortality rate: 13/1000
Contraceptive Prevalence rate 15-49 (2006): any method: 81; modern methods: 80
Proportion of births attended by a skilled health professional: 99.3 (2000), 97.3 (2006), 99.5 (2009)
Source: (UN Stats)
Unmet Need: (2012) 6.9 (UNDESA)

Background

Thailand is renowned for its successful family planning programme, developed well before the Universal Health coverage scheme in 2002²¹¹. Although the country's current TFR is now below replacement level, the government discarded its previous pro-natalist stance on fertility and espouses an individual choice-based approach to family planning, recognizing the human right of every person to determine when, where, and how many children to have.²¹² Usage of modern methods of contraception is high, reported at 80% in 2006. Thailand made huge strides in the past few decades with regard to improving MMR and IMR, in no small part affected by the implementation of successful community-

based healthcare programmes, as well as the universal health insurance scheme, which greatly improved access to reproductive healthcare for all citizens, regardless of income level. Additionally, Thailand's emphasis on increasing the capacity and training of midwives and nurses at the sub-district health centre level have contributed greatly to improving maternal and child health (and SRH in general)²¹³. In fact, near-universal skilled birth attendance (99.5%) and Antenatal Care attendance (99%) rates were reported in 2009, remarkably regardless of geographic location, education, or other markers of socioeconomic status.²¹⁴ Moreover, where HIV/AIDS presented a huge emerging public health threat in the past, the epidemic was stymied by a famously successful HIV-prevention campaign aimed at promoting education and condom-use (particularly among sex workers).²¹⁵

As Thailand is meeting or has met many of its targets towards the fulfillment of the Millennium Development Goals, the Thai government and the National Economic and Social Development Board has set higher standards to guide their development (and SRH) agenda post-2015, referred to as the MDG+ targets²¹⁶.

Current Scope of SRH Policy Agenda

The first National Reproductive Health Policy (supplanting the Family Planning programme) was launched in 1997, following Thailand's participation and subscription to the goals set forth at the ICPD in 1994. The Policy focuses on FP, MCH (including EmOC), HIV/AIDS (including a programme to address mother-to-child HIV

211.Viroj Tangcharoensathien et al. Universal Coverage and Its Impact on Reproductive Health Services in Thailand *Reproductive Health Matters* 2002;10(20):59–69

212.UNFPA country profiles 2009-2010 p. 169

213.Viroj Tangcharoensathien et al., Universal Coverage and Its Impact on Reproductive Health Services in Thailand *Reproductive Health Matters* 2002;10(20), p. 59

214.Suratchada Kongsri, et al. Equity of access to and utilization of reproductive health services in Thailand: national Reproductive Health Survey data, 2006 and 2009 (2011) p. 86

215.UNFPA country profiles 2009-2010 p. 169

216.Health Policy in Thailand 2009 Ministry of Public Health p. 55

transmission)²¹⁷, sex education (using a life-skills based approach), infertility and reduced fertility, RTI/STI/HIV prevention and treatment, RH cancer management and early detection, and adolescent and elderly reproductive and sexual health issues²¹⁸. Gender-based violence was later added to the list, leading to the development of programmes promoting male responsibility and participation in women's reproductive health rights and improving adolescents' reproductive health.²¹⁹

The Policy is notable for being effectively integrated into the national public health system, especially on the primary healthcare level, and most notably incorporated into the essential package of services covered by the Universal Health Plan in order to guarantee access to SRH services to all (married)²²⁰ women. The 1997 NRHS took a life-course approach to SRHR provision and protection, asserting that all Thai citizens, of all ages, must have good reproductive health throughout their lives.²²¹ The Ministry of Public Health stressed the need to place particular attention to meet the needs of previously underserved populations, particularly in rural areas.²²²

Other relevant policies and bodies

National Plan for Prevention and Alleviation of HIV/AIDS (2002)

Implemented in 2002, this now famously-successful place took a multi-sectoral approach to engage all levels of Thai society by establishing social welfare services, promoting

community participation, and targeting particularly at-risk populations to combat the spread of and mitigate the damage caused by HIV/AIDS.²²³

Health Systems Management for SRH

Thailand's decentralized approach to healthcare is possibly the key to its success in extending SRH services across all sub-districts. The backbone of its health programmes is the effective management of its primary healthcare system, based on four pillars: community organisation and people's participation; health system re-orientation' intersectoral collaboration' and acquisition and maintenance of appropriate technology.²²⁴ The first of these related to the Thai government placing part of the onus on the population to engage in active health-seeking behaviour, what it terms as the 'principle of self-reliance', encouraging communities to take a role in solving its own health problems.²²⁵ Apropos to this, Thailand's public health strategy focuses heavily on building up community-based human resources for health, including the training of village-level community health worker volunteers and community-based trained healthcare professionals.²²⁶ Of course, the success of this approach also relies equally on strong political stewardship and intersectoral collaboration. To this effect, while the promotion, management, and coordination of Thailand's healthcare services (including for SRH) are all overseen by the Ministry of Public Health, other agencies performing significant roles are the Ministry

217.Yongpanichkul p. 10

218.UNFPA Country profiles 2009-2010 (2010) p. 169

219.Yongpanichkul, Siriporn. A Review of Sexuality and Reproductive Health and Rights in Thailand. Ford Foundation (2006) p. 8

220.ICOMP Improving Access of Young People to Education and Services for Sexual and Reproductive Health, HIV, and Gender: Promising practices in Indonesia, Thailand and Vietnam (2009) p. 11

221.Viroj Tangcharoensathien et al., Universal Coverage and Its Impact on Reproductive Health Services in Thailand.Reproductive Health Matters 2002;10(20):59–69

222.Yongpanichkul 2009 p. 9

223.Yongpanichkul p. 10

224.Health Policy in Thailand 2009 Ministry of Public Health p. 42

225.Health Policy in Thailand 2009 Ministry of Public Health p. 42

226.Ibid., p. 48

of Education, of Interior, of Defense, the Bangkok Metropolitan Administration, state enterprises, and private-sector entities²²⁷. Moreover, the Ministry of Social Development and Human Security has taken over as the main body addressing issues surrounding SRHR and Gender Equality.²²⁸

In terms of financing, since the inception of the primary healthcare system in 1979, funding has been provided and managed by the central government, international donors, and an external revolving fund for primary healthcare activities financed by communities. The Ministry of Public Health finances the acquisition of essential drugs and other SRH commodities for the most part, although these are also available through village-level providers and drug cooperatives.²²⁹

Universal Health Care Coverage

In 2001, Thailand adopted a massively-successful and affordable Universal Health Care Coverage Scheme to allow those who were excluded from social insurance schemes due to poverty to have access to a comprehensive package of basic health services. The package includes preventive and treatment services for most aspects of SRH. In 2006, antiretroviral treatment for HIV/AIDS was included²³⁰. Safe abortion, however, is only covered by law for rape victims and for high-risk cases. Users were required to pay an out-of-pocket 30 baht (approx. USD 1.00) fee for services (however, the fee is waived for those who cannot afford it). As of 2006, this fee was waived for all citizens.²³¹

Highlights of Case Study

- SRH services and healthcare facilities available across all districts and sub-districts due to a decentralized approach to health service provision and management, and a very strong community-based primary healthcare programme²³²

- Universal Health Coverage for all citizens, free of charge, including a substantial RH service package.

- Highly successful public health campaign to control the spread of HIV/AIDS, involving the concerted and collaborative efforts of the Thai government and international donors, NGOs, and other stakeholders

- Strong CSO/Governmental partnerships to improve SRH service delivery and health promotion

Current National Priorities

- Adolescent pregnancy

- Infertility

- Population Ageing

- Better integration of SRH programme implementation across government departments

- Low level of exclusive breastfeeding, low birthweight, and maternal mortality due to AIDS²³³

227.Ibid., p. 23

228.Yongpanichkul p. 19

229.Ibid. p. 49

230.Asia Pacific thematic papers: Beyond MDGs and the ICPD 2012 p. 27

231.Bureau of Policy and Strategy, Ministry of Health, Thailand. Thai Health policy (2009) p. 26

232.Yongpanichkul p. 19

233.Suratchada kongsri et al 2011 p. 91

CAMBODIA

Indicators

Population Size (in thousands) (2012): 14 478
p.c. GDP (2011): 897
% Urban population (2012): 20.1
% Population under 15 (2012): 31
% Population over 60+ (2012): 5 (M), 8 (W)
Annual population growth rate (2010-2015): 1.2
Total fertility rate (2010-2015): 2.42
Adolescent fertility rate (2010-2015): 32.9/1000
Sex ratio (women per 100 men) (2012): 104
Maternal Mortality rate (2010): est. 250 (per 100,000.
b.) CI 95 [160-390]
Infant mortality rate (2010-2015): Total 53/1000;
Under 5 mortality rate: 69/1000
Contraceptive Prevalence rate 15-49 (2005): any
method: 40% modern methods: 27%
Proportion of births attended by a skilled health
professional: 31.8 (2000), 43.8 (43.8), 71.7 (2011)
Source: (UN Stats)
Unmet Need: 16.9% in 2011 (UNDESA)

Background

Despite having seen a steady decline in poverty levels and improvements in health and education indicators, Cambodia remains one of the least-developed countries in the Asia-Pacific region²³⁴. Among the many development challenges it faces are its persistently high maternal mortality rate (250/100,000 in 2010), incidence of violence against women, STI knowledge and incidence among young people, and skilled birth attendance (although there have been marked improvements in this regard despite a continued shortage of midwives). Nonetheless, significant progress has been made in the area of SRH service provision, not least beginning with the prioritization of reproductive, maternal, newborn and child health by the government stated in the Health Strategic Plan (2008-2015)²³⁵, following a separate National

Strategy for Sexual and Reproductive Health drafted for the 2006-2010 period.

Current Scope of SRH Policy Agenda

Health Strategic Plan (2008-2015) (or HSP2)

As part of its overarching strategy, the HSP2 states its aims to 'Scale up access to and coverage of health services, especially comprehensive reproductive, maternal, newborn and child health services both demand and supply side through mechanisms such as institutionalization and expansion of contracting through Special Operating Agencies, exemptions for the poor, health equity funds, and health insurance'²³⁶. Along with explicitly setting all SRH issues across the life course high on the general health agenda, the HSP2 also proposes a plan to improve the quality of service delivery and management by drafting and enforcing national protocols and clinical guidelines, address cross-cutting challenges like gender and hygiene through collaboration with other sectors, and to promote effective public and private partnerships. The Plan concludes by setting a thorough implementation plan including timeline for annual reviews to monitor progress (and a list of indicators by which to evaluate progress), and an evidence-based costing plan.

National Strategy for Sexual and Reproductive Health (2006-2010) (Revised 2008)

The NSRH likewise covers all aspects of SRHR issues, including Maternal and Newborn Health, Adolescent Reproductive and Sexual Health, Family Planning, Reproductive Tract

234. WORLD BANK RH at a Glance 2011 p. 2

235. UNFPA and Population Reference Bureau. Country Profiles for Population and Reproductive Health: Policy Developments and Indicators for 2009-2010(2010). P. 118

236. HSP2 (2008-2015) 2008. p. 13

Infections and Sexually Transmitted Infections, Gender Based Violence, Other Gynecological Conditions, Commodity Security, and Human Resources. Additionally, the strategy includes and operational framework, as well as how managing health service delivery, health financing, health information system, system governance, complete with indicators and targets for progress in implementation. The Strategy's stated objectives are: improve the policy and resource environment; increase availability and strengthen delivery of quality services; improve community understanding and increase demand for services; and expand the evidence base for policy and strategy development.

Other relevant policies and bodies:

- Child Survival Strategy (CSS)
- Five Year Strategic Plan for National Immunization Program (FYSPNIP)
- National Nutrition Strategy (NNS)
- The National Action Plan to Combat Violence Against Women (in accordance with the 2005 Law on the Prevention of Domestic Violence and Protection of Victims)

Health Systems Management for SRH

Health systems management and measures for good governance are encapsulated by the current Health Strategic Plan. The HSP2 outlines a system-wide approach with five main characteristics: Accountability, Efficiency, Quality, and Equity²³⁷. The Plan offers a detailed, time-bound plan of action to implement measures for greater transparency and accountability, for monitoring and evaluating the impact of policy and programmes, to manage health service

delivery, for an integrated approach to high-quality health service delivery and public health interventions, health care financing (including a coverage plan), human resources for health, management of health information knowledge to inform policymaking, and governance with an aim towards a decentralized and de-concentrated system. The HSP2 also includes a timeline, budget, and a detailed monitoring framework to track progress with regard to its implementation.

Partnerships

Ministries: Education, Youth & Sport, Information, Interior, Planning, Rural Development, Social Affairs, Women's Affairs

MOH Departments: Central Medical Stores, Essential Drugs, Human Resource Development, Planning & Health, Information, Hospital Services, Preventive Medicine

Associations/Councils: Cambodian Medical Association, Cambodian Medical Council, Cambodian Midwives Association

INGOs: Cambodian HIV/AIDS Education and Care, (CHEC), Cambodia Health Education Media Service

(CHEMS), Indradevi association (IDA), Khmer HIV/AIDS NGO Alliance (KHANA), MARIE STOPES Cambodia (MSC), Mith Samlanh (Friends), Operation Enfants de Battambang (OEB), Reproductive and Child Health Alliance (RACHA), Reproductive Health Association of Cambodia (RHAC), Women's, Development Association (WDA), Women's Media Centre of Cambodia (WMC)

Bilateral Agencies: Dept for International Development (DfID), European Union (EU), 'German Cooperation' (KfW / GTZ),

Japanese International Cooperation Agency, (JICA), United States Agency for International Development (USAID), Canadian International Development Agency, (CIDA), Agency France Development (AFD)

INGOs: Adventist Development and Relief Agency (ADRA), CARE International in Cambodia (CARE), Family Health International/ (FHI), HealthNet International (HNI), Health Unlimited (HU), Medecins Sans Frontieres-Belgium (MSF-B), Partners for Development (PFD), Pharmaciens Sans Frontieres (PSF), Population Services International (PSI), Program for Appropriate Technology in Health

(PATH), Save the Children-Australia (SCA), Services for Health in Asia and African, Regions (SHARE), University Research Cooperation (URC), Voluntary Services Overseas (VSO), World Relief Cambodia (WRC), World Vision Cambodia (WVC)

Development Partners: WHO, UNFPA, UNICEF, USAID, DFID, AUSAID, ADB, GTZ, Marie Stopes, FHI

Highlights of Case Study

- Comprehensive and detailed National Sexual and Reproductive Health Strategy drafted in 2006 to address persisting issues in poor SRH performance underpinning other development issues, almost completely in line with the principles and strategic outcomes suggested by the ICPD Plan of Action.

- Agenda and strategy outlined by the NRHS (2006-2010) fully incorporated into the most recent general National Health Strategy (2008-2015), recognizing SRH issues as crucial to development and national health in general.

- Key weakness: missing detailed strategy for addressing youth issues

Current National Priorities

- Focus on reducing unacceptably high maternal mortality rate, newborn and child morbidity

- Reduce morbidity and mortality caused by HIV/AIDS, Malaria, TB and other Communicable Diseases.

- Improving access to services (by addressing both economic barriers and human resource shortages)



III. HOW CAN CHINA BENEFIT FROM THESE EXAMPLES?

China's health and population programmes are in a pivotal process of transition. After the success and demographic consequences of the strict family planning policy, China is re-focusing its sexual and reproductive health policies to improve governance, equity, efficiency and efficacy. Building on the success of policies to address specific issues such as lowering maternal mortality rates (resulting in a decrease in the maternal mortality rate of 66.3% since 1990)²³⁸, China is now engaged in a process of expanding policies and programmes to address a wider range of issues in sexual and reproductive health. A number of challenges for comprehensive SRH services exist including a high burden associated with some issues (widespread gender-based violence²³⁹, including son-preference²⁴⁰; emerging reproductive health concerns such as STIs, reproductive cancers, and infertility; a high burden of HIV infection; etc), along with structural problems within the health system resulting in inequitable access to services for some populations (rural populations^{214/242}, adolescents, migrant populations, etc). Moreover, there are some key areas within SRHR for which no dedicated strategy yet exists.

The country's most recent developments in health system reform have been well-documented by national and international scholars²⁴³ - and there is a particular interest

in gleaning lessons from China for other developing countries wishing to strengthen their health system capacities without hampering economic development. The comprehensive health reform plan launched in 2010 by the Chinese government was a particular point of interest for such academic analysis²⁴⁴. After having shifted from an entirely state-governed health service delivery model to one driven by the free market, with mixed success, China began seeking a middle ground to its general health system approach, one which guarantees a basic level of universal coverage while giving the private sector room to fill gaps. The national government has identified a number of strategic priorities, including: the upgrading of primary health delivery, the provision of a list of essential medicines, and achieving full coverage and equitable use of services across the entire population under existing programmes such as the New Cooperative Rural Medical Scheme (NCRMS), Medical Financial Assistance (MFA) program, and the Urban Resident Basic Medical Insurance (URBMI) scheme.

The reforms are expected to be fully operational by 2020; moreover, the bulk of the existing literature on assessing the progress of such reforms is confident in their likelihood of success²⁴⁵. In relation to SRH, in 2009 the central government began providing subsidies for nine categories of basic

238. NCWCH 2011, p. 9

239. Jiuling Wu et al. Sexual abuse and reproductive health among unmarried young women seeking abortion in China (2006)92, p. 186

240. Barber, Sara L., Lan Yao. Health Insurance Systems in China: A Briefing Note. World Health Report (37). WHO (2010), 25

241. Hana Bixi et al. Equity and Public Governance in Health System Reform: Challenges and Opportunities for China. The World Bank (2011), 7

242. NCWCH 2011, p.9

243. Bloom, Gerald. Building institutions for an effective health system: Lessons from China's experience with rural health reform. Social Science & Medicine 72 (2011) 1302-1309 p. 1302

244. c.f. Bixi et al (2011), Bloom (2011)

245. See above cited

healthcare, including maternal and infant care, immunization programmes, and health education²⁴⁶. However, reproductive health packages covered by national insurance plans are incomplete, and SRH services remain both fragmented (especially when linking family planning with other sexual and reproductive health needs) and unsatisfactory in terms of offering a range of choices to clients, particularly at the lowest levels of primary healthcare²⁴⁷. Addressing these issues will require the coordinated efforts of various government bodies, including the National Health and Family Planning Commission, the Ministry of Finance, the Ministry of Education, All China Women Federation, and National Working Committee on Women and Children .

A window of opportunity currently exists for the development of a comprehensive set of policy and programme directives to improve SRHR and enable Chinese citizens to achieve their individual SRHR goals. The process of health sector reform, a growing burden of SRH problems, and the present cabinet's stated goal to ensure equal access to basic health services for all citizens, provides a "policy window" which can be acted upon now. In this report, we have reviewed not only the underlying concepts and principles which are the bedrock of SRHR, but have also outlined the international commitments to improving SRHR that have been made by most countries – including China. Our review of how thirteen other countries have developed and formulated policies for SRHR provides some guidance on the steps that China might take, but also highlights some of the likely challenges which will be faced. In summary, our key messages from reviewing these case studies in the light of the conceptual frameworks outlined in the first section of the report are the following:

1. **SRHR is fundamental to promoting and protecting the health of populations**, to advancing human wellbeing, and to ensuring services respond to the needs of individuals. While SRHR commitments have been made by a large number of countries, fewer countries have gone on to develop comprehensive SRHR policies and programmes.
2. **A supportive legal and policy framework is crucial** to enable individuals to achieve their SRHR goals. International commitments to promote and protect SRHR have been used to guide the content of national Government policies, as well as providing mechanisms to hold Governments to account by individuals, communities and in particular by affected communities. China already has a large number of national laws in place which can be used to promote and protect SRHR goals.
3. **Accountability is vital**. Mechanisms for accountability have been used in other ongoing frameworks within SRHR – in particular, the HIV-UNGASS and Independent Expert Review Group for women and children's health. These mechanisms not only enhance the core concept of accountability, but also improve transparency and may act to increase the efficiency of systems.
4. SRHR should be realized by everyone in a population, but **the exact needs of individuals vary** according to socio-demographic and other factors (age, location, gender, sexual orientation, etc). Programmes at national level have recognized that different groups in society have different needs, and services have been directed to respond to the needs of these different groups.

246.NCWCH (2011), 23

247.Shanlian Hu, et al. Health System Reform in China 6: Reform of how health care is paid for in China: challenges and opportunities. The Lancet (2008), 74

5. **Health care financing mechanisms for SRHR vary** between countries – ranging from general taxation, and hypothecated taxation, through to donor financing. Deciding on individual Government responsibilities for financing of a core package of SRHR services is vital.

6. Moving from single-issue reproductive health programmes (e.g. family planning programmes) towards comprehensive SRHR policies and programmes has tended to **proceed in a step-wise fashion** in many countries. Many of the countries reviewed are still in the early stages of SRHR service delivery and are focusing on a restricted package – e.g. concentrating on improving reproductive health programmes. Other countries, with longer histories of SRHR services, are able to deliver more comprehensive models of care that are accessible to the whole population, as well covering a larger number of programmatic components.

7. Most policies reviewed focus on preventing disease rather than on promoting wellbeing or enabling rights. This may be missing some of the more important (but less tangible) aspects of SRHR such as wellbeing, mental health associated with sexuality, concepts of pleasure and satisfaction, etc. Furthermore, **programmes which take a more holistic approach and focus on all aspects of SRHR have been shown to be more acceptable to clients**, and have improved impact in some cases^{248/249}.

8. **Monitoring and evaluation are crucial.** The more comprehensive programmes measure not only disease-based outcomes, but also take user perspectives into account.

9. **Improvements in SRHR begin with the health sector, but cannot be achieved by the health sector alone.** The role of legal, educational and other sectors is crucial. Cross-sectoral collaboration is vital.

Moving forward, we believe that the lessons learnt from other countries, particularly when reviewed in the light of underlying core concepts and principles of SRHR, will be useful in strengthening China's existing SRHR policies and expanding the scope, reach, and quality of SRHR programmes.

248. Ouma A. J., A. van der Kwaak (2009) Promoting Sexual Health for Young People in Kenya: The Family Health Options Kenya Sexuality Counselling Approach, Amsterdam: KIT.

249. Sampaio Chacham, A. and A. Martin Hilber (2009) Promising practices of sexuality counselling: the experience in Brazil (Coletivo Feminista de Sexualidade e Saúde). Amsterdam: KIT

APPENDIX 1: KEY DEFINITIONS OF SRHR

“**Reproductive health** implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy child.”

(World Health Organisation [WHO])²⁵⁰

“**Reproductive rights** embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.”

(International Conference on Population and Development [ICPD] 1994)²⁵¹.

“**Sexual health** implies a positive approach to human sexuality and the purpose of sexual health care should be the enhancement of life and personal relations as well as counselling

and care related to reproduction and sexually transmitted diseases”

(WHO working definition)²⁵²

“**Sexual rights** embrace human rights that are already recognised in national laws, international human rights documents and other consensus documents. These include the right of all persons, to be free of coercion, discrimination and violence, to live to the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services; seek, receive and impart information in relation to sexuality; sexuality education; respect for bodily integrity; choice of partner; decide to be sexually active or not; consensual sexual relations; consensual marriage; decide whether or not, and when to have children; and pursue a satisfying, safe and pleasurable sexual life.”

(WHO working definition)²⁵³

“**Sexuality** is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.”

(WHO working definition)²⁵⁴

250. Report of the International Conference on Population and Development. United Nations (1994). New York (1995), p. 40. <https://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd_eng.pdf>.

Also refer to: WHO <http://www.who.int/topics/reproductive_health/en/>.

251. United Nations (1995), p. 40. <https://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd_eng.pdf>.

252. Defining sexual health: report of a technical consultation on sexual health, 28–31 January 2002, Geneva. World Health Organisation, Geneva (2006). <http://www.who.int/reproductivehealth/topics/gender_rights/defining_sexual_health.pdf>.

253. World Health Organisation (2006), p. 5.

254. WHO (2006), p. 5

APPENDIX 2: SELECT LAWS IN RELATION TO SRH IN CHINA

LEGAL AGE OF SEXUAL CONSENT

No law/policy for a particular age, but the Criminal Law (1997)ⁱ has defined having sex with a girl under age 14 as rape, as detailed below:

Article 236. Whoever, by violence, coercion or other means, rapes a woman is to be sentenced to not less than three years and not more than 10 years of fixed-term imprisonment.

Whoever has sexual relations with a girl under the age of 14 is to be deemed to have committed rape and is to be given a heavier punishment.

Whoever rapes a woman or has sexual relations with a girl involving one of the following circumstances is to be sentenced to not less than 10 years of fixed-term imprisonment, life imprisonment, or death:

- (1) rape a woman or have sexual relations with a girl and when the circumstances are odious;
- (2) rape several women or have sexual relations with several girls;
- (3) rape a woman in a public place and in the public;
- (4) rape a woman in turn with another or more persons;
- (5) cause the victim serious injury, death, or other serious consequences.

LEGAL AGE OF CONSENT TO MARRIAGE

Male 22, Female 20 - Marriage Law (2001)ⁱⁱ

LEGAL MULTIPLE SPOUSES

Only monogamy is legal - Marriage Law (2001)

RECOGNITION OF RAPE IN MARRIAGE

No law/policy for recognition of rape within marriage

GENDER BASED VIOLENCE LAWS THAT RECOGNISE SEXUAL VIOLENCE AGAINST WOMEN, MEN, CHILDREN

Criminal Law (1997)

Article 236. Whoever, by violence, coercion or other means, rapes a woman is to be sentenced to not less than three years and not more than 10 years of fixed-term imprisonment.

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- (1) rape a woman or have sexual relations with a girl and when the circumstances are odious;
- (2) rape several women or have sexual relations with several girls;
- (3) rape a woman in a public place and in the public;
- (4) rape a woman in turn with another or more persons;
- (5) cause the victim serious injury,

death, or other serious consequences.

Article 240. Those abducting and trafficking women or children are to be sentenced to 5 to 10 years in prison plus fine. Those falling into one or more of the following cases are to be sentenced to 10 years or more in prison or to be given life sentences, in addition to fines or confiscation of property. Those committing especially serious crimes are to be sentenced to death in addition to confiscation of property.

(1) Primary elements of rings engaging in abducting and trafficking women or children;

(2) those abducting and trafficking more than three women and/or children;

(3) those raping abducted women;

(4) those seducing, tricking, or forcing abducted women into prostitution, or those selling abducted women to others who in turn force them into prostitution;

(5) those kidnapping women or children using force, coercion, or narcotics, for the purpose of selling them;

(6) those stealing or robbing infants or babies for the purpose of selling them;

(7) those causing abducted women or children, or their family members, to serious injuries or death, or causing other grave consequences;

(8) those selling abducted women or children to outside the country.

Abducting and trafficking women or children refers to abducting, kidnapping, buying, selling, transporting, or transshipping women or children.

Article 241. Those buying abducted women or children are to be sentenced to three years or fewer in prison, or put under criminal

detention or surveillance.

Those buying abducted women and forcing them to have sex with them are to be convicted and punished according to stipulations of article 236.

Those buying abducted women or children and illegally depriving them of or restricting their physical freedom, or injuring or insulting them, are to be convicted and punished according to relevant stipulations of this law.

Those buying abducted women or children and committing crimes stipulated in paragraphs two and three of these articles are to be punished for committing more than one crime.

Those buying and selling abducted women or children are to be convicted and punished according to article 240 of this law.

Those buying abducted women or children but not obstructing bought women from returning to their original residence in accordance with their wishes, or not abusing bought children and not obstructing efforts to rescue them, may not be investigated for their criminal liability.

Article 242. Those using force or coercion to obstruct workers of state organs from rescuing bought women or children are to be convicted and punished according to article 277 of this law.

Primary elements who lead other people to obstruct workers of state organs from rescuing bought women or children are to be sentenced to five years or fewer in prison or put under criminal detention. Other elements that use force or coercion are to be punished according to paragraph one of this article.

CRIMINALISATION OF HOMOSEXUALITY, MALE, FEMALE

No law/policy for criminalization of homosexuality

CRIMINALISATION OF SEX WORK, MALE, FEMALE

Criminal Law (1997)

Section 8. The Crime of Organizing, Forcing, Seducing, Harboring, or Introducing Prostitution

Article 358. Those organizing others for or forcing others into prostitution are to be sentenced to five to 10 years in prison in addition to having to pay a fine. Those falling in one or more of the following cases are to be sentenced to 10 years or more in prison or given a life sentence, in addition to a fine or confiscation of property:

- (1) Those committing serious crimes of organizing others for prostitution;
- (2) those forcing young girls under the age of 14 into prostitution;
- (3) those forcing more than one person into prostitution and those repeatedly forcing others into prostitution;
- (4) those forcing others who were raped by them into prostitution;
- (5) those causing severe injuries, death, or other serious consequences to those who are forced into prostitution.

Those committing one or more of the above crimes, if the case is especially serious, are to be given a life sentence or sentenced to death, in addition to confiscation of property.

Those helping others organize people for prostitution are to be sentenced to five years or fewer in prison in addition to a fine. If the

case is serious, they are to be sentenced to five to 10 years in prison in addition to being fined.

Article 359. Those harboring prostitution or seducing or introducing others into prostitution are to be sentenced to five years or fewer in prison or put under criminal detention or surveillance, in addition to paying a fine. If the case is serious, they are to be sentenced to five years or more in prison in addition to a fine.

Those seducing young girls under 14 years of age into prostitution are to be sentenced to five years or more in prison in addition to a fine.

Article 360. Those engaging in prostitution or visiting a whorehouse knowing that they are suffering from syphilis, clap, or other serious venereal diseases are to be sentenced to five years or fewer in prison or put under criminal detention or surveillance, in addition to having to pay a fine.

Those who visit young girl prostitutes under 14 years of age are to be sentenced to five years or more in prison in addition to paying a fine.

Article 361. Personnel of hotels, restaurants, entertainment industry, taxi companies, and other units who take advantage of their units' position to organize, force, seduce, harbour, or introduce others to prostitution are to be convicted and punished according to articles 358 and 359 of this law.

Main persons in charge of the aforementioned units who commit crimes stipulated in the above paragraph are to be severely punished.

Article 362. Personnel of hotels, restaurants, entertainment industry, taxi companies, or other units who inform law offenders and

criminals while public security personnel are checking prostitution and whorehouse visiting activities, if the case is serious, are to be convicted and punished according to article 310 of this law.

CRIMINALISATION OF PURCHASING SEX

Refer to related content in Criminal Law (1997) Article 360 and Article 362 attached earlier.

GENDER REASSIGNMENT INCLUDING AGE

No particular law/policy for gender reassignment, but some transgender people have successfully changed gender status on their residence record since the 2000s.

CRIMINALISATION OF PORNOGRAPHY

Criminal Law (1997)

Section 9. The Crime of Producing, Selling, or Disseminating Obscene Materials

Article 363. Those producing, reproducing, publishing, selling, or disseminating obscene materials with the purpose of making profits are to be sentenced to three years or fewer in prison or put under criminal detention or surveillance, in addition to paying a fine. If the case is serious, they are to be sentenced to three to 10 years in prison in addition to having to pay a fine. If the case is especially serious, they are to be sentenced to 10 years or more in prison or given life sentence, in addition to a fine or confiscation of property.

Those providing others with international standard book numbers [ISBN] for publishing obscene books or magazines are to be sentenced to three years or fewer in prison or put under criminal detention or surveillance, in addition to having to pay a fine; or are to be fined. Those providing others with ISBNs knowing that they are going to use them

for publishing obscene books or magazines are to be punished according to the above stipulations.

Article 364. Those disseminating obscene books, magazines, films, audio or video products, pictures, or other kinds of obscene materials, if the case is serious, are to be sentenced to two years or fewer in prison or put under criminal detention or surveillance.

Those organizing the broadcasting or showing of obscene motion pictures, video films, or other kinds of audio or video products are to be sentenced to three years or fewer in prison or put under criminal detention or surveillance, in addition to having to pay a fine. If the case is serious, they are to be sentenced to three to 10 years in prison in addition to paying a fine.

Those producing or reproducing and organizing the broadcasting or showing of obscene motion pictures, video tapes, or other kinds of audio or video products are to be severely punished according to stipulations in paragraph two of this article.

Those broadcasting or showing obscene materials to minors under 18 years of age are to be severely punished.

Article 365. Those organizing an obscene performance are to be sentenced to three years or fewer in prison or put under criminal detention or surveillance, in addition to paying a fine. If the case is serious, they are to be sentenced to three to 10 years in prison in addition to having to pay a fine.

Article 366. Units committing crimes stipulated in articles 363, 354, or 365 of this section are to be fined, and their main persons directly in charge and other personnel directly responsible for the case are to be punished according to stipulations of respective articles.

Article 367. Obscene materials mentioned in this law refer to erotic books, magazines, motion pictures, video tapes, audio tapes, pictures, and other obscene materials that graphically describe sexual intercourse or explicitly publicize pornography.

Scientific products about physiological or medical knowledge are not obscene materials.

Literary and artistic works of artistic value that contain erotic contents are not regarded as obscene materials.

ACCESS TO CONTRACEPTION, AGE RESTRICTIONS, COVERED UNDER INSURANCE

Population and Family Planning Law (2001)ⁱⁱⁱ

Article 19 Family planning shall be practised chiefly by means of contraception.

The State creates conditions to ensure that individual citizens knowingly choose safe, effective, and appropriate contraceptive methods. Where birth control operations are performed, the recipients' safety shall be ensured.

Article 20 Couples of reproductive age shall conscientiously adopt contraceptive methods and accept technical services and guidance for family planning.

Incidence of unwanted pregnancies shall be prevented and reduced.

Article 21 Couples of reproductive age who practise family planning shall receive, free of charge, the basic items of technical services specified by the State.

The funds needed for rendering the services specified in the preceding paragraph shall, in accordance with relevant State regulations, be listed in the budget or be guaranteed by social

insurance plans.

Article 22 Discrimination against and maltreatment of women who give birth to baby girls or who suffer from infertility are prohibited. Discrimination against, maltreatment, and abandonment of baby girls are prohibited.

CRIMINALISATION OF STI/HIV TRANSMISSION AND COMPULSORY PARTNER NOTIFICATION

For Sexually Transmitted Infections:

Criminal Law (1997)

Article 360. Those engaging in prostitution or visiting a whorehouse knowing that they are suffering from syphilis, clap, or other serious venereal diseases are to be sentenced to five years or fewer in prison or put under criminal detention or surveillance, in addition to having to pay a fine.

Guidelines for Management of Prevention and Treatment of STDs (2012)^{iv}

Article 30. Health workers who conduct diagnosis and treatment for STDs should tell the patients to notify their sexual partner(s) and make the partner(s) visit a clinic as soon as possible.

For HIV/AIDS:

Regulations on AIDS Prevention and Treatment (2006)^v

Article 38. People with HIV positive and AIDS patient shall perform the following obligations:

- (1) Accept epidemiological investigation and direction of agencies of diseases control and prevention or inspection/quarantine;

(2) Inform the fact of being infected or suffering the disease to their sexual partner in time;

(3) Inform the fact of being infected or suffering the disease to their medical doctor when they come to see the doctor;

(4) Take necessary precaution measures to prevent others being infected.

People with HIV positive and AIDS patient shall not, on purpose, spread the infection to others by any means

i.Criminal Law (1997): <http://www.fmprc.gov.cn/ce/cgvienna/eng/dbtyw/jdwt/crimelaw/t209043.htm>

ii.Marriage Law (2001): http://www.npc.gov.cn/englishnpc/Law/2007-12/13/content_1384064.htm

iii.Population and Family Planning Law (2001): http://www.gov.cn/english/laws/2005-10/11/content_75954.htm

iv.MOH Guidelines for Management of Prevention and Treatment of STDs (2012): <http://wsb.moh.gov.cn/mohzcfgs/s3576/201212/cba30083e498409f913515da47cee7.shtml>, not available in English.

v.Regulations on AIDS Prevention and Treatment (2006): http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legal_document/wcms_113144.pdf

APPENDIX 3: DELIVERING SRHR: COMPONENTS AND SERVICE DELIVERY

PROVISION OF FAMILY PLANNING SERVICES

Family planning services have been core to population, development and reproductive health programmes for at least 20 years. The benefits of access to contraceptive services include not only the ability to regulate fertility, including through birth spacing, but also an impact on maternal and perinatal morbidity and mortality. Access to contraceptive information and services enables couples and individuals to decide freely and responsibly the number and spacing of children; to have information and means to do so; and to ensure they make informed choices and make available a full range of safe and effective methods, which is of particular benefit to promoting gender equality and women's rights²⁵⁵.

Unmet need (defined as women who are not using any method of contraception but do not desire more children or would like to space their pregnancies) and total contraceptive use levels (or 'proportion of demand satisfied') make up the total demand for family planning, and are useful, dynamic measures by which to monitor the progress and efficacy of family planning services and interventions.

Comprehensive family planning programmes should include information about the availability and range of services, advantages of FP, efficacy of methods and possible side effects, and any contraindications of contraceptives. Services should ensure the availability and provision of a wide range of

acceptable, safe, and high-quality methods of family planning, in addition to providing appropriate screening, counseling and follow-up services.

Crucially, family planning should also be seen within the context of more comprehensive SRHR needs. Family planning programmes can provide an entry-point to tackle other health and relationship needs, including discussions about healthy and positive aspects of sexuality.²⁵⁶

INFERTILITY AND ASSISTED FERTILITY SERVICES

The Revised WHO-ICMART glossary defines Infertility as "a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse."²⁵⁷ This is further sub-divided into primary and secondary infertility:

- **Primary Infertility:** When a woman is unable to ever bear a child, either due to the inability to become pregnant or the inability to carry a pregnancy to a live birth

- **Secondary Infertility:** When a woman is unable to bear a child, either due to the inability to become pregnant or the inability to carry a pregnancy to a live birth following either a previous pregnancy or a previous ability to carry a pregnancy to a live birth

Both types of infertility have implications for the well-being of the couple (or woman)

255. ICPD PoA 1994

256. WHO 2004 p.22

257. F. Zegers-Hochschild et al. The International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organization (WHO) Revised Glossary on ART Terminology, 2009. Human Reproduction, Vol.24, No.11 pp. 2683–2687, 2009 doi:10.1093/humrep/dep343

affected, be it enduring social stigma and abuse according to the value their society places on child-bearing, negative mental health outcomes, economic disadvantage, or morbidity caused by the underlying reasons for infertility- for example as a result of sexually transmitted infections in either men or women.

Assisted Reproductive Technologies (ART) including in-vitro fertilization and embryo transfer, gamete intra-fallopian transfer, oocyte and embryo donation, and gestational surrogacy can aid individuals and couples in the treatment of causes of infertility/delayed/problematic.²⁵⁸ However, ART services are often prohibitively costly, and often only available in the private sector. In order to become more cost-effective and widely available, (in)fertility management prevention and intervention measures should be incorporated into the existing sexual and reproductive health framework. A strategic approach to addressing infertility should furthermore include considerations for both prevention and care. A substantial proportion of infertility may be preventable in some settings by reducing the incidence and prevalence of tubal infertility through STI control. Once a man or woman is infertile, then an approach to simplify diagnostic and treatment procedures, minimizing complications, and incorporating fertility centers into existing SRH (incl. family planning) clinics²⁵⁹ is needed.

MEASURES TO ADDRESS UNSAFE ABORTION

Unsafe abortion is a preventable cause of maternal mortality and morbidity, which continues to contribute to a substantial burden

of disease for women in many countries. At the International Conference on Population and Development held in 1994, this issue was both controversial (due to its legal status in many participating countries) but also universally framed as a major public health concern. To that effect, paragraph 8.25 of the Plan of Action states that “all Governments and relevant intergovernmental and non-governmental organisations are urged...to deal with the impact of unsafe abortion as a major public health concern and reduce the recourse to abortion... In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions.”

UNFPA promotes the use of contraception and strengthening of family planning services to avoid unintended pregnancies with a view to limiting the need for abortions. However, it also recognizes that services need to be available to avoid deaths and morbidity associated with unsafe abortion in contexts where social mores prohibit the right of a woman to exercise control over her own body. WHO stipulates that provision of safe abortion services requires “training health service providers in modern techniques and equipping them with appropriate drugs and supplies, all of which should be available for gynecological and obstetric care; providing social and other support to women with unintended pregnancies; and, to the extent allowed by law, providing abortion services at primary health care level. For those women who suffer complications of unsafe abortion, prompt and humane treatment through post-abortion care must be made available.”²⁶⁰

258.F. Zegers-Hochschild et al., p. 2685

259.Ombelet, Willem. Reproductive healthcare systems should include accessible infertility diagnosis and treatment: An important challenge for resource-poor countries. International Federation of Gynecology and Obstetrics (2009) p. 170

260.WHO Reproductive Health Strategy to accelerate progress towards the attainment of international development goals and targets 2004 p.22

MATERNAL AND CHILD HEALTH CARE SERVICES

Maternal and Child Health lie at the heart of reproductive health strategies across the world, with two millennium development goals (MDGs 4 and 5) devoted to improving health outcomes for women and children. Countries, such as China, that have made great strides in reducing preventable maternal and child mortality and morbidity can attribute some of this success to strong political will and strategic interventions²⁶¹.

Maternal deaths are often reflections of the levels of social and economic disparities in a country - women who are disproportionately affected are those from lower income and social status. Most maternal deaths occur at the moment of, or just after, delivery and in resource poor settings this is often a result of uncontrolled hemorrhaging or unhygienic conditions where the birth is occurring.²⁶² For infants, the burden of mortality and morbidity has shifted to those infants who die in the first month of life—44% of all under-5 deaths occur at this time²⁶³. The concept of “ending preventable deaths” in this population has not yet been quantified, but a Lancet Commission highlighted that an under-5 mortality rate of 16/1000 live births should be achievable in most low- and middle-income countries (compared to the current rate in developing countries of 99/1000 live births)²⁶⁴.

Integrating the goals of SRH programmes with those of maternal and child health programmes is fundamental to achieving

comprehensive, holistic policies and programmes which enable SRH goals to be reached by all. Maternal and child health services are fundamental to good SRH outcomes, and should be delivered at all levels of the health system – including at the household/community level, outpatient and outreach settings, and clinical care settings (primary, secondary or above)²⁶⁵. Delivery of maternal and child health programmes is reliant upon having trained and multiply-skilled health workers who are able to deliver services across the life cycle.²⁶⁶

SEXUAL HEALTH

As noted previously, sexual health encompasses and addresses concepts of sexuality of all persons, regardless of gender, age, reproductive capacity or sexual orientation. Distinct sexual health programmes are few and far between, but many countries deliver a range of services which address aspects of human sexuality beyond their reproductive health needs. These include but are not limited to services addressing: mental health in relation to sexuality and gender; sexual dysfunction; violence related to gender inequality, sexual orientation, sexual identity and gender identity; harmful and traditional practices related to sexual health (e.g. female genital mutilation and a range of practices associated with negative health outcomes),. There is some evidence that addressing these issues within existing SRH services can increase the overall acceptability and impact of services²⁶⁷.

261. UNFPA future we want for all p. 2

262. WHO 2004 p. 22

263. Lawn JE, Blencowe H, Oza S, You D, Lee AC, Waiswa P, Lalli M, Bhutta ZA, Barros AJD, Christian P, Mathers C, Cousens S. Every Newborn: progress, priorities and potential beyond survival. *Lancet* 2014;384(9938):189-205.

264. Mason E, McDougall L, Lawn JE, Gupta A, Claeson M, Pillay Y, Presern C, Lukong MB, Mann G, Wijnrocks M, Azad K, Taylor K, Beattie A, Bhutta ZA, Chopra M. From evidence to action to deliver a healthy start for the next generation. *Lancet* 2014;384(9938):250-9

265. Kerber et al. 2007 p. 1358

266. Bustreo et al. *Bulletin of the WHO* 2013; 91: p. 622

267. See, for example: Sampaio Chacham, A. and A. Martin Hilber (2009) Promising practices of sexuality counselling: the experience in Brazil (Coletivo Feminista de Sexualidade e Saúde). Amsterdam: KIT and uma A. J., A. van der Kwaak (2009) Promoting Sexual Health for Young People in Kenya: The Family Health Options Kenya Sexuality Counselling Approach, Amsterdam: KIT.

STI/HIV/RTI PREVENTION AND TREATMENT

Sexually transmitted infections, including HIV, exert a significant burden of disease (morbidity and mortality) on individuals and their partners – both sexual partners and mother-child partnerships.

There are many effective and cost-effective interventions which can be delivered to decrease the incidence (and reduce overall prevalence) of STIs/HIV, including²⁶⁸:

Primary prevention: vaccines (e.g. HPV vaccine); sexuality counseling; screening to prevent mother to child transmission of HIV and/or syphilis

Secondary prevention: screening (using aetiologically-based diagnostics) for the presence of infection and treating those infected; management of people with symptoms; prevention of onward transmission to sexual partners through partner notification programmes.

Tertiary prevention: management of the complications of STIs/HIV including infertility management, treatment and management of people living with HIV/AIDS, and treatment regimens for women with cervical cancer.

While challenges and barriers exist in the process of integrating services and provision of STI/RTI and HIV prevention and treatment, there is evidence that linking these services (e.g. through counseling and education on sexuality and inter-partner relationships, or simply bolstering referral systems) can promote the increased use of SRH services and overall quality of care.²⁶⁹

REPRODUCTIVE CANCERS (SCREENING PROTOCOLS, PREVENTION, TREATMENT)

Cervical cancer and its precursor, cervical intra-epithelial neoplasia (CIN) contribute substantially to the burden of preventable morbidity and mortality suffered by women. Cervical cancer is caused by oncogenic human papilloma virus (HPV) – and prevention and treatment of these conditions are feasible even within resource-constrained settings. A comprehensive prevention and control programme includes ensuring access to the HPV vaccine, while simultaneously strengthening the delivery of high quality screening and treatment services for women in older age groups.

New diagnostics and new technologies have enabled the promotion of “screen and treat” strategies which have ensured that screening services and allied treatment are now being devolved to the lower levels of health care – thus increasing the coverage of screening, and also improving treatment coverage in many settings.

GENDER BASED VIOLENCE, INCLUDING SEX-RATIO IMBALANCE

Violence against women is prevalent across the globe and carries serious threats to women’s health and well-being. Women who are subjected to violence are likely to suffer a number of adverse outcomes (physical, psychological, socio-economic), including SRH consequences such as adverse reproductive health outcomes, sexual trauma, and mental ill-health. Violence takes many forms ranging from the interpersonal to the structural,

268. Low N, Broutet N, Yaw Sarkodie A, Hossain M, Barton P, Hawkes S. Global control of sexually transmitted infections. *Lancet*. 2006;368(9551):2001-16.

269. WHO Reproductive Health Strategy to accelerate progress towards the attainment of international development goals and targets (2004), 22

and addressing the root causes of violence is as important as ensuring that survivors of violence have access to affordable and effective care and support packages. The World Health Organization classifies violence against women as a major public health problem. The context of GBV is interlinked with underlying social, cultural, religious and gender norms and with political conflict where that exists. Gender-based violence is not, however, limited to women, and there is an increasing body of evidence to show that men, too, can be subjected to emotional, physical and sexual violence both from other men as well as from their partners.

There are often many barriers to women (and men) accessing appropriate care and support when they suffer violence. Such barriers exist within the health system, but are also seen in the judicial and justice sectors.

A comprehensive SRH policy agenda should include measures to ensure that services are available for women (and men) who have suffered violence, and also addressing the systems, structures and beliefs that perpetuate gender power imbalances and allow violence to continue. Key aspects of GBV which require responses include, but are not limited to: domestic abuse, sexual violence (and associated mental health issues), female genital mutilation, female infanticide due to son-preference and prenatal sex selection, forced marriage, 'honour' crimes, forced pregnancy and forced abortion, forced sex work and trafficking. Special attention should be given to marginalised populations and those particularly vulnerable to gender-based violence, such as women in crisis settings and armed conflict suffering from systematic (sexual) violence, and those living in remote areas.

The WHO recommends integrating services for sexual abuse and gender-based violence into SRH service packages. Specifically, it lists a need for the evaluation of current policies and practices relevant to sexual violence, as well as the coordinated efforts of health services, social welfare agencies, police and legal prosecutors, and non-governmental service providers. Moreover, it calls for the development of guidelines for medical, psychological, and forensic care for victims, for health workers to be also specially trained in identifying and dealing with cases of possible abuse, in tandem with making confidential counselling services easily available²⁷⁰.

Prenatal sex selection and sex-ratio imbalance

Countries affected by sex-ratio imbalance due to son preference (including India and China) have attempted several different approaches to deal with sex-selective abortion, including legal restrictions on the use of neonatal screening technologies, but these policies by themselves fail to address the issues of gender inequality underpinning the problem, and risk limiting individual freedom to family planning as a side-effect. Indirect measures, however, such as laws to guarantee equitable patterns of inheritance, subsidies to encourage families to have female children, gender-based school quotas, coupled with awareness and advocacy campaigns to alter prevailing attitudes towards women and girls are thought to have better prospects for effecting lasting change, although more research must be conducted to determine what measures are most (cost-) effective.

What is clear, however, is that primary, secondary, and tertiary prevention methods to address the effects of gender-based violence must be embedded into SRHR policy, and that

270.WHO: Sexual Violence: Strengthening the Health Sector Response 2014. http://www.who.int/violence_injury_prevention/violence/activities/sexual_violence/en/, see also: PREVENTING INTIMATE PARTNER AND SEXUAL VIOLENCE AGAINST WOMEN: TAKING ACTION AND GENERATING EVIDENCE.

a longer-term strategy must be implemented to change the social norms responsible for perpetuating abusive behaviour.

MENTAL HEALTH IN RELATION TO SRH

There are a number of mental health issues in relation to SRH, the most common of which is probably sexual dysfunction - this is an extremely common condition (age-related) which leads to a variety of sexual health problems. However, while the problems of sexual dysfunction are relatively well described in many settings, the ability of health systems to address conditions affecting an estimated 8-33% of the adult population²⁷¹ during their lifetime, is less clear. In many countries the issues of mental health and wellbeing in relation to sexuality are only addressed within the private sector – thus calling into question health equity.

The SRH needs of people with mental health problems are often neither well understood nor well addressed within SRH or allied programmes – but should be the focus of equitable and effective programmes to improve the health of all.

271.Laumann E, Paik A, Rosen R (1999). Sexual dysfunction in the United States: Prevalence and predictors. *Journal of the American Medical Association*, 281:537–544.

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